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A PATHOLOGIST'S EXPERIENCE WITH ATTITUDES TOWARD DEATH

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Introduction

I AM DEEPLY HONORED to have been asked to present this annual memorial oration in the memory of Doctor Isaac Gerber. I did not have the privilege of knowing him personally, but have read his contributions and his biography. This has made understandable the preference of your Committee for the broad comprehensive topic selected, *Our Attitude Toward Death*. Doctor Gerber's life epitomized the wholesome, the constructive and the positive. He was one of that rare and disappearing breed of clinicians who made the patient the focal point of his effort. He elevated diagnosis and treatment to a research status. He grasped the new and applied it successfully. His research thus was realistic and practical. As you well know, his very illness was considered another sacrifice so many of our early pioneers in radiology made. The attitude toward death in the face of a long illness, shown by your beloved Doctor Gerber, bespeaks a healthy, sane, rational, creative philosophy of life, with its emphatic concern for his colleagues and the community, and yielded that equanimity that "removes the sting" and "smooths the bed of death." Our topic then is a fitting and proper one for this occasion, for it is our attitude toward life, the motivation and direction of our daily efforts and our goals that determines our viewpoint toward death. It is with a spirit of humbleness and anxiety that I present this analysis to you, for a more eloquent speaker and a profound theologian and philosopher, rather than a mere pathologist, would be required to do justice to this topic in the memory of this great man.

Death is a natural phenomenon; yet fear of death is often an exaggerated dread, even though one possesses deep-rooted traits of courage and general stability. Firsthand observation over some thirty years of people who are dying, and of the reactions of members of the family, is the basis for this recital of experience and this interpretation of attitudes toward the event of death. The fortitude and adjustment a person may possess can forsake him in the event of the death of a loved one. At such times, it is good to be buttressed with an understanding of this natural phenomenon as an actuality which must be faced as natural, inevitable and irrevocable. Interviews with many families following death, in attempting to obtain an autopsy consent, have led to the conviction that one of the most potent causes for the exaggerated emotional upheaval that ensues is to be found in the denial of the reality of death. This denial confirms the inadequacy of the doctrine of fleeting existence only and of man's yearning need for immortality.

This unrealistic refusal to accept the fact of death as such is given expression by such recurring statements as "impossible," that it "just couldn't be." When the emotions continue to reject the reality of death, the bereaved family will refuse consent for autopsy. They attempt to deny death's finality by denying examination of the body. The initial immediate spontaneous refusal to consent to an autopsy on the part of the average individual is understood best on the basis of this subconscious impulsive refusal to accept the death of the loved one. The family wishes to keep the body as they last saw and felt it, i.e., as alive as possible. They do not want the body touched, because they have a deep-rooted hope that the body will remain as it is, and an equivalent subconscious hope that it will reawaken and come to life again. They are, in effect, denying death in denying the examination of the body. The autopsy must needs confirm death finally and irrevocably.

It is this writer's experience that this reaction can usually be controlled and overcome by a rational discussion of its mechanism and motives. If adults faced with such a crisis had grown up with matter-of-fact discussions on death, they

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would have developed a wholesome attitude instead of the fear that overwhelms them. This gives us the basis for hope that proper education of the child can do much toward the establishment of a fully realistic and wholesome attitude toward life and death.

The material of this essay will be divided into several parts:

1. Clinical Observations
2. Ideas concerning the after-life
3. Psychological factors in the individual
4. Care of the dying
5. Care of the dead body
6. Comments and recommendations

Clinical Observations

There have been numerous studies of individuals who are about to die, both those who do possess the realization of their approaching demise and of those who lack the awareness. Difficult as it is to accept the death of a loved one, it is even more difficult to accept death as an eventuality for oneself. Most individuals adopt a mechanism which again is, in a measure, a denial of the reality of death as it applies to themselves. We have all seen physicians and nurses who know the malignant and hopeless character of their ailment, and yet persist in believing that they will not die now and that somehow they will recover. Death is for the other fellow.

This mechanism of denial of the unpleasant reality of death on the part of most of us, should be considered in determining the policy of withholding information of the absolute hopeless character of an illness from the majority of patients. At the present juncture, with our present conditioning and mores, the promotion of some measure of hope is indicated, scant though it may be, to make the terminal period psychically less painful. Each individual personality must be evaluated and full divulgence varied accordingly. We have observed individuals with cancer who have been made completely aware of their condition, and also those from whom this degree of hopeless certainty has been withheld. It is the firm conviction of this writer that the latter patients, who do not have every vestige of faith and hope denied them, have a better attitude toward their illness and to their demise. At times it even seems that the ravages of the disease itself are less marked in them. The disadvantage of withholding the truth from the patient should not be overlooked. With education and fuller understanding we may be able to tell the whole truth to more patients in the future. On the other hand, absolute hopelessness need not be admitted to the patient by the most honest physician, for recovery often does occur in apparently hopeless illnesses.

One can dispose very readily of the misconception that pertains to the act of dying or the period of agony. There is much evidence at hand, both on the part of people who have recovered after cardiac massage and also by close observation of patients during the period of agony, to establish the fact that panic and exaggerated fear do not usually appear. Patients who recover because of cardiac massage may be unaware how mortally ill they were. Subtle terminal and terminating biochemical changes usually remove consciousness or substitute a toxic expansive exhilaration, which makes the legend of dread, so often associated with the act of dying, entirely unfounded. This occurs in both sudden and slow deaths. Only rarely does a sharpened perception appear preterminally. This fact should mitigate some of the distress felt by the bereaved, whose grief may become uncontrolled at the thought of suffering.

The fear of the corpse itself is consciously determined by the strangeness of its cold feel, the unnatural pallor, the wide-eyed glazed expression, the total absence of movement, and the awe of the event as established by the behavior of others. This is particularly true when emotional stress and earnest grief, which cannot be controlled, overcome individuals present. A single intense experience is usually sufficient to condition a child or adult to our usual reaction pattern.

An important element of the fear associated with death in the past has been the fear of burial alive. Individuals have demanded an autopsy examination to establish beyond doubt the fact that death has occurred. The compulsory autopsy, after a legal execution, acknowledges this fear. As noted, the autopsy consent is often denied unwittingly, because the procedure eliminates any possibility of revival.

Ideas Concerning the After-Life

Part of our conditioning to death depends upon the relationship of death to birth, and that death is but part of the birth process for the spirit. The idea of rebirth after death is common in primitive people, with many survivals in our own civilization. Burial in the intrauterine fetal position is undoubtedly linked with this thought, and dates back to the Cro-Magnon man. Burial itself has the germ of the idea of germination of the seed to be reborn. We are returned to "Mother earth." The doctrine of reincarnation is a prominent one in many faiths, as with the Hindu. To perpetuate the name of the deceased is another variant. Many still prefer a son to carry on in one's name. The relationship of sex to death has both conscious and unconscious mechanisms. The Mohammedan heaven after death has an important sexual component, part of which is the fecundity of birth. The peace and serenity of

death has been linked with the state of physical and mental relaxation following the orgasm, an interpretation of Nirvana by some.

The widespread acceptance of the belief in the survival of the soul after death follows from the understandable refusal of rational man to accept all existence as impersonal and meaningless with ultimate complete extinction of the personality. The physical is segregated from the psychic, which is endowed with life ever-after, and the personality of the deceased is thus perpetuated. This doctrine has been a most potent force in the evolution of civilization and in shaping our personal behavior and religious patterns. Let us recall sutteeism, the ascetic monk of the Middle Ages, or the Australian aborigine who murdered his parents at their own earnest plea, to assure their transcendence to the spiritual world while at the height of their physical prowess.

The fear of death is attributable in no small measure to the fear of punishment in the hereafter for transgressions during life. Concern for the hereafter, fear of implacable justice after death have shaped our moral and ethical code. Special prayers for the benefit of and the comfort of the departed spirit are part and parcel of the religious ritual in many faiths. This expected accounting for the temporary stay on this earth of the spirit, should not paralyze all productive and creative effort, for then it may negate all purpose and meaning of life itself. Concern for our sins does not necessarily demand a fear mechanism or dread such as was stressed in the "memento mori" of the Middle Ages, or in our modern era by our own brimstone revivalists. The fear of retribution here and in the hereafter has the fundamental of implacable justice. It is this fundamental of the scales of blind justice that prompts most of us to repress the experience of death as too charged, for welcome or mature present consideration.

Some of our fear of death is still linked to the dread of the returning inexorable spirit. Our behavior and our action are often directed to placate the spirit, so that it will not return as a vengeful force or demon. It is natural for survivors to visualize that separation by death may stir a resentment on the part of the departed. This deep-rooted awareness prompts deferential care of the departed. There is a widespread taboo about using the name of the deceased or the prohibition against the use of the name of the deceased without placating phrases as, "may he rest in peace," "good soul." Taboos, as they involve death, are numerous and in no small part occasioned by the insoluble conflict between the ambivalent, simultaneous conscious grief and an unconscious satisfaction, with consequent feelings of guilt. Only rarely does this satisfaction reach a conscious level, as when one near and dear dies after a prolonged painful illness, or after a long period of mental deterioration or helpless invalidism. Much of the irrational reaction to death in the past and today, can be traced to this fear of the anger and the vengeance of the spirit.

Many foibles associated with death are motivated by our desire for earthly immortality. The monument, big or small, the cemetery, ugly and crowded or spacious and ostentatious, our very efforts for fame and glory; all represent attempts at immortality, and a denial of the implication of physical destruction and total annihilation in death. Man's demand throughout the ages for a male heir or a large family represents procreation to achieve earthly immortality.

Psychological Factors in the Individual

If we can overcome the anxiety and fear of the act of dying, actual agony, burial alive, or the dead human body *per se*, and the premeditation of death as a coming certainty, then what is the fundamental basis of our fearful and disturbed attitude toward death? We must still cope with the general fear of the boundless *Unknown*, and this explains much of the unpleasant and the unwelcome aspects of the death event. We are balancing abstract values in the conscious realm.

The unreasonable exaggeration of such an emotional reaction, to give us fear and dread, is what should and can be controlled. The Thracians rejoiced at a death and wept at a birth. Aversion for the loss of those near and dear, or our own going, with separation from them, is reasonable. The resulting void that follows cannot be denied, nor the grave eliminated. Grief may be enormous, but our reaction and our adjustment to it should be controlled and possess a healthy pattern. By the same token we can feel keenly, but yet attempt to fill the gap left by our loss with other interests and activities. The pain and grief in the severance of pleasant relations with others, has been phrased by Friedrich Longau:

"Ich fürchte nicht den Tod, der mich zu nehmen kümmt
Ich fürchte mir den Tod, der mir die Meinen nimmt."

The psychological mechanisms, though so very powerful, are very subtle. Psychiatrists stress that much of the conflict, repression and psychopathology encountered in the experience of death, is due to the ambivalence of our reaction toward death. This really is a trivalence at least, it includes both the love for the deceased and a simultaneous hate and fear. The fear is often stirred by a sense of guilt initiated by the repression of actual hate, and also by past events or feelings of aggression and transgression; all often quite deeply subcon-

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scious. The survivors may be wracked with conflict between the conscious grief of bereavement and the subconscious relief, all mixed with feelings of guilt. Such individuals usually are adamant in their refusal to consent to an autopsy and just cannot control their emotional reactions at funerals; all of which may be quite genuine in that the inner problems are subconscious. The demand for immediate decisions about such matters, as autopsy consent, funeral arrangements, burial or cremation, crystallize the conflict and lead to unwitting repressions, rationalizations and compromises. Much of the irrational reaction to death can be traced to this fear of the anger and vengeance of the departed spirit. Underlying the refusal of permission for autopsy may be the fear of what vengeance the dead person may visit upon the one who grants permission for work on the body of the deceased.

We may find the important phenomenon of compensation. It has been our experience that, given a husband who has a genuine love for his wife, one can overcome the initial objection and obtain consent for a post-mortem examination. The experience, however, is quite different with the husband who has been beating his wife regularly and never did feel a genuine love. Almost invariably, this husband will not permit her dead body to be touched. He goes to extremes in protecting it. He usually wishes an elaborate funeral. This does not represent unselfish compensation in the form of expiation only, for there is also a patent attempt to meet a deep-rooted selfish fear of retribution and reprisals.

When the relative has contributed to the death by unwitting failure or willful neglect or inadequacy, the mechanism of compensation is often more forceful but may be less obvious superficially. When a mother takes an adamant stand against an autopsy without a sound objection, she may do so because consciously or subconsciously she is aware that she has failed to call a physician in time. Or in like manner, the father may be plagued by his negligence or inadequacy as a provider. This is also seen in the sensitive husband whose wife dies at childbirth. He feels deeply because he initiated the process.

Care of the Dying

One of the indices of a civilization is to be found in the care it devotes to the stricken, the dying and the dead. When death is inevitable, it is the duty of the physician to minimize the pain and anguish and offer comfort to the family and friends.

Euthanasia presents grave legal, moral, religious and ethical problems. For the present the physician had best not embroil himself in these issues. The dignity of the human being and the meaning of life is the issue at stake. The physician plays God if he goes beyond the control of pain and suffering and actively shortens the terminal period. Initiated as a means of shortening agony, will it end as a matter of convenience for the state or the family? Are we to apply euthanasia to the hopelessly deformed, the imbecile, the permanently deteriorated, the inebriate? Where do we draw the line and desist? Apparently here the all-or-none law of the beating heart must apply without compromise. Life is full of too many mysteries, our understanding of its full meaning too inadequate and futile, to justify the prerogative of destroying it. In a legal execution we do just that and our civilization will some day, we trust, find this destruction of precious life degrading too. This barbarous penalty has already been abolished for many crimes as civilization has advanced.

One can also properly raise the question whether the physician is justified in prolonging life unduly when all hope is gone and suffering is the only lot remaining. Should he continue transfusions, infusions, potent drugs and oxygen merely to lengthen life by prolonging the act of dying? Such a meaningless victory can result in untold anguish and insupportable financial burdens. Again the physician should not assume an omniscience he does not possess. Death itself can be a comfort and a physician today is sometimes capable of withholding for days, weeks or months, that one comfort. He may be bringing death into life, prolonging death, not life, and in so doing failing in his obligation to curtail suffering.

Care of the Dead Body

It is the attitude toward the ordinary more physical and tangible aspect of our everyday experience with death, i.e., the care of the dead human body, which can be remedied most readily. By accepting its ultimate physical destruction as a fact, and instituting an automatic immediate administrative procedure for its care and the preferred ceremonial, we can help materially in the proper orientation of the individual and the group, toward a healthier concept of death. The historical aspect of the physical care of the dead human being is fascinating, but time will hardly permit a detailed presentation. We have, on the one hand, the primitive reaction which leaves the corpse as is, to lie and decompose unattended, or flight from the sick or dying individual, with all sympathy, pity and all thought of helpfulness overcome by fear. In contrast, we have the other primitive response, so close to our own unreal attitude, which refuses to accept death and keeps the corpse among the living until decomposition is far advanced. The variations in human procedure as it affects the corpse includes cannibalism, its disposal in a tree or in mounds or in caves. Interment, simple, without embalming as in the Jewish

faith, or elaborate attempts at preservation as with the ancient Egyptians; cremation, alone or with living members of the family and household; and burial at sea, these do not complete the entire range of actual human experience. We have the gamut from the attempt at immediate destruction to the attempt at perpetual preservation, and numerous permutations and combinations.

Discussion and Recommendations

Death represents one of the few true certainties of life and is the most equalizing and democratizing force about us. Much of our emotional reaction and aftermath of conflicts is based on perversion of religious doctrine, a carry-over of deep-rooted superstition, the demands of ingrained custom, and improper conditioning and education. At best, death is an unpleasant experience, and nothing that we may do or say can ever alter that fact. It is probably better so, for it would seem to imply that the experience of living is pleasant. Our energies are now directed toward financial security for survivors, and this is the major objective of our social security program. Just as important, if not more so, is an organized directed effort by the family and the community to fill the void of separation with wholesome creative activities and deeds of achievement, to tap hidden sources of psychic energy for renewed stimulation, to overcome the exhausting depressing grief and bring a sense of meaningful purpose into the lives of survivors. This need is now not adequately provided for and so often left to chance and the overwhelmed individual, with dire psychological results, despite financial security and is sometimes worsened by it.

We know today that by examining the dead body most deaths have an adequate explanation. Belief in the natural causes of death is consistent with the belief in the will of the Almighty. Acceptance of natural cause is often mere lip service. The soldier in battle shows this faith best, for he often sees adventitious circumstances determine life or death. Refusal to consider death as an immediate possibility represents an attempted solution of the problem by psychological repression. Reasonable thought about the problem of death is possible without undue fear of the actual event of death. We will be accepting the reality of death when we prepare for our own and for those near and dear, without emotional tension and without procrastination. We should look upon such preparation as an opportunity to project the personality into the future, to do good after life—a universally satisfying and reasonable form of immortality.

We can translate these thoughts into action. Every person should have a legal will and testament no matter how small the estate. Dying intestate often means an unnecessary wasting of assets and a failure to project one's wishes. The expressed wish as to the disposal of the remains can be a source of comfort for all. Good administrative procedure at the time of death, automatically initiated, can do much to minimize anxiety for it can reduce the need for painful decisions to a minimum. This must include a scientific consultative procedure for death certification, which will also give stability and reliability to our mortality statistics. In modern society, humans die often under circumstances where a member of the family is not at hand to protect the person or the property of the deceased. Jurisdiction, without delay, is imperative. In our community the dead human body is looked upon as property, and the laws of inheritance apply. Provision for legal identification and claim of the remains, and the responsibility for its disposal must be specific. Social insurance schemes in many countries now take cognizance of this aspect of human existence and cover expenses to the grave. Incidentally this final human need can be standardized for state control much more readily than medical care for obvious reasons. The meeting of this need by a social program should take precedence and can do much to establish a national administrative routine and a sane, controlled reaction to the event of death.

Acceptance of the rational care of the dead body can do much to overcome the widespread denial of reality in the event of death. As part of the procedure of the care of the dead human body, and to favor a proper orientation toward the physical aspect, routine autopsy examination should be encouraged. This implies the full acceptance of death and the possibility of a contribution by the body itself to furthering knowledge and of doing good. The autopsy must also become a meticulous scientific instrument of investigation of disease, as well as a thorough analytical means of determining the cause of death. It is of interest that modern rational regulations of death certification originated in England, and were propounded by a Society endeavoring to promote cremation as a means of disposal of the dead. Modern legal and scientific death certification was initiated by this group.

The education of our children must include their introduction to the reality of death. They must accept it, as it applies to the physical form, as a natural inevitable event, resulting in permanent loss of the physical presence. The comfort of faith and the promise of spiritual future existence can well be offered, in keeping with one's own particular religious doctrine, divorced from the supernatural. But above all, the truth must prevail, and death must factually mean a permanent physical loss in the present sphere. Contrary to the usual opinion, children can endure trying emotional experiences of this type better than adults. They should not be

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REPORT OF AN ORTHOPEDIC SURVEY OF 5,000 ISRAELI CHILDREN*

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MY SUBJECT, *Orthopedic Survey of 5,000 Israeli Children*, perhaps requires some preliminary explanation. These examinations of children between the ages of four and fourteen years were all undertaken by a single observer. They comprise the children in some fifteen of the many communal settlements in upper and lower Galilee, one of the largest being Dan of *Exodus* fame.

These communal settlements or Kibbutzim are essentially farming or agricultural centers originally founded in the first and second decade of this century by the true Zionist Idealists. At that time, Palestine, through neglect, had been allowed to become a morass of deadly swamps in the north and of unyielding arid desert in the south. The good lands on the coastal strip were hard to come by and so these Jewish pioneers went out in groups to establish their Kibbutzim in the midst of the most unfriendly and frequently treacherous surroundings. They drained the swamps where malaria had become endemic. They tamed the deserts; monotonous sands changing slowly into vast fertile tracts covered with grains, fruits and vegetables of endless luxuriant varieties. These hardy pioneers founded a society where every man was considered equal, where hard physical labor was prized as just as honorable an occupation as any other, where personal materialism was considered a cardinal sin—nobody owned anything for himself but yet considered himself to be abundantly rich. They established a truly classless society based on the land. They considered their children to be their gold and their true wealth—to take over and to continue the good work of their parents.

One of the first laws enacted by the Israel Knesset or parliament after the foundation of the State in 1948 was the "Law of Return" which guaranteed the right of every Jew to immigrate to Israel. Thus the Jewish population since this time has more than trebled. The right to immigrate was not limited by any kind of qualification but was dictated by the urgent need to save Jews from persecution and annihilation in certain countries. Many immigrants came from countries with a low cultural standard where a democratic regime is unknown and where the citizen does not even enjoy the most primitive services in the field of education and health. The association of people with such different backgrounds, cultures and value systems; people who differ so greatly in their habits of food and housing, in their social relations and language provided a sociological problem of great magnitude, and this stream of immigrants was intentionally diverted to the rural districts. It is one of the basic principles of Zionist philosophy to transform the Jews—which had become town dwellers by force of history—into a nation rooted in the soil of their own country. The Kibbutzim opened their gates wide to receive and integrate the massive influx of immigrants as they poured into the land. Today the Kibbutzim have become a melting pot for all groups from many and varied lands, and they can be said to provide a true cross-section of the heterogeneous population of Israel today.

In our day-to-day orthopedic consultant practice we are constantly being faced with many conditions whose bases are some or other postural defect, and it is apparent that much of this could be obviated if we had the opportunity of treating these defects at their inception during childhood. Thus it appeared to be an ideal opportunity to do an orthopedic survey in the Kibbutzim and to prescribe preventive treatment at an early age. Here we have a static community and we could be certain that treatment would be carried out, as advised, irrespective of expediency or expense, and that the follow-up in these cases would be ever so much simpler.

This paper is merely the initial and preliminary report of a work undertaken in a field research survey. There are no startling discoveries to be announced. We plan to do a follow-up every four years and we hope that eventually we will have some of the answers which we are seeking.

WEIGHT. Kibbutz boys compared with American boys. We found that in general, Israeli boys

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were somewhat lighter than their American counterparts. The average birth weight is about equal. At the age of four years the difference is approximately one pound; at the age of eleven years the difference is about six pounds, and at fourteen years the difference is about fourteen pounds.

It should be remembered that many immigrant children are included in these figures, children who have suffered disease and malnutrition before their arrival and whose development has thus been retarded. Also this includes children of hereditary small stature and slight of build. For example, the average weight of an adult Yemenite male is 40 kilo or 88 pounds. The comparative figures taken four and eight years later should prove of interest.

STATURE. Kibbutz boys compared with American boys. Again, American boys were found to be slightly taller.

At the age of four years the difference is minimal, at six it is just under one inch while at fourteen there is a difference of 2½ inches. A quick survey taking into consideration only those boys born and brought up on the Kibbutz shows that they are much taller and heavier built than their American counterparts; but this is possibly not a true reflection as any rural American group living a far more active, healthy and robust life than their city cousins would be above the national American average for height and weight. It has been established that second generation Jews born in Israel are taller and more strapping than their parents and this, as I understand, has been found to be equally true here in America.

Apropos, it is also of interest to note here that the incidence of stress-environment-diet diseases such as arteriosclerosis, coronary heart disease and high blood pressure is minimal in immigrants from the poorer and more backward countries, where life is leisurely and the diet rich in carbohydrate but poor in proteins and fats, and that in the second and third generations born in Israel where the diet is somewhat richer and the tensions of modern living more apparent the incidence of these diseases soon approach the national average. Much interesting research work is at present being done on this.

Mobile Valgus Heels: Here we refer to heels which are everted on standing but which are readily correctible. When baby first begins to stand, mother almost invariably worries about baby's so-called flat feet. At this age, the evertors of the foot are more powerful than the invertors; the arch tends to lean inwards on its side, so producing the appearance of a flattened longitudinal arch and this in the infant becomes even more pronounced as the instep is filled in by a pad of baby fat. It should be realized that the arch has not collapsed but that it has merely tilted onto its side.

Mobile valgus heels were seen in 52% of children of all ages. We observe that at the age of four years 80-90% of all children display mobile valgus heels, and we may thus quite confidently believe this to be a normal finding in this age group. After this the incidence drops rather steeply until the age of ten years, and thereafter somewhat more gradually until the age of fifteen years when 18% boys and 6% girls remain with M.V.H. This latter group then is our only real problem and all efforts are concentrated on finding some common factors in those feet where the valgus persists. Here, it appears, that the initial degree of valgus is not the

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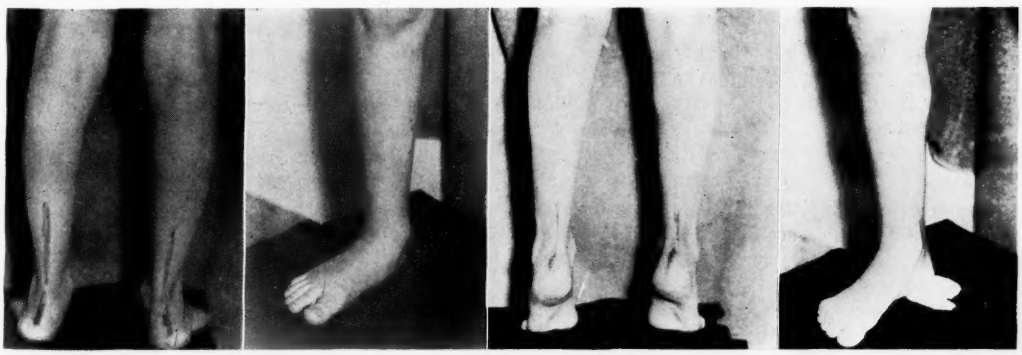

FIGURES 1, 2, 3 and 4

Fig. 1: ***Mobile Valgus Heels.*** **The tendo-achilles and the vertical line of the calcaneus have been penciled on the skin and show the angle of varus.**

Fig. 2: ***Mobile Valgus Heels.*** **The same case showing the apparent flattening of the longitudinal arch.**

Fig. 3: ***Mobile Valgus Heels.*** **Here the boy is standing on his toes. In this position both the tibialis anterior and posterior are acting more powerfully than the two peroneals; the heel is pulled into varus and the reconstituted bow-like arch can be clearly seen.**

Fig. 4: ***Mobile Valgus Heels.*** **With a ½ cm. wedge under the medial aspect of the calcaneus, the tendo-achilles pulls in a straight line, the arch is reconstituted producing a normally aligned plantigrade foot.**

important factor.

Now many of these children had previously been supplied with metal, leather or plastic arch supports, but it is maintained that these pernicious supports do little more than perpetuate the muscle imbalance. The invertors are not called upon to pull the heel in; they begin to atrophy and years later when the child does try to do without supports he may suffer unbearable pain. Arch supports, in these cases is not a treatment, but is, virtually a life sentence.

Few, if any, of these growing children complain of painful feet which can be definitely ascribed to their valgus heels. Pain apparently becomes a real problem only after puberty. We have now managed to have discarded all arch supports in the Kibbutzim. Initially, some children complained of some discomfort or even pain but this was soon forgotten.

All children are now encouraged to play barefooted on their toes, on the lawns and in the sand. Special games for this purpose have been devised. In the more pronounced cases, special exercises are given to strengthen the invertors of the foot and we sometimes advise a ½ cm. inner wedge to the heel of the shoe, in order to improve the alignment of the calcaneus.

Further investigations were indicated only in those cases where the heel was fixed in valgus and could not be corrected. In the entire series, there were only two such cases found—both caused by congenital calcaneo-navicular bars. One is at present pain free;—the other has already come to surgery.

There were some 35% of children of all ages whose posture was considered poor. We are all well acquainted with the picture of a child—age about five years — who stands with a swayback, protuberant abdomen, hyperlumbar lordosis, genu recurvatum, genu valgum, intoeing and mobile valgus heels. Here again we have a natural improvement with the years. As the child grows stronger so he tends to stand straighter with a corresponding improvement of body alignment.

Of note, is the sudden upward spurt in the incidence of poor posture in girls about and just after puberty. It has been suggested, not without some reason, that this sudden increase in the percentage for girls is associated with their rapidly developing breasts and that they tend to assume a faulty posture with hunching of the shoulders and forward tilting of the head in a partially subconscious effort to hide these fast-growing protuberances.

Our problem is the 20% boys and girls whose faulty posture persists after childhood, as the majority of these are sure candidates for low back pain and other postural defects at a later age. All the children are now receiving regular daily exercise. The girls are encouraged to participate in such activities as rhythmic dancing and the boys in sports such as gymnastics and basketball.

We have found the perplexing problem of idiopathic scoliosis of great interest. The term "idiopathic scoliosis" is surely the diagnosis of the destitute, and over the years little if any progress has been made in the understanding of its etiology. This survey did not concern itself with paralytic scoliosis, scoliosis due to neurofibromatosis or any other known cause, but we confined ourselves to this large group of scolioses of which the cause, as yet, remains a secret. We have retained the accepted classification into two main groups: The purely postural or functional scoliosis where the lateral curvature of the spine persists no matter how straight the child attempts to stand but where the curve unwinds itself and straightens out on full flexion—and then the fixed or structural scoliosis where the curve persists on forward flexion with the formation of a razor back due to the persisting rotation of the vertebral bodies. This latter group, of course, is the only serious type which may progress rapidly producing grotesque deformities of the trunk and not infrequently becoming a danger to life. Those cases showing rapid deterioration require stabilization by fusion and it would certainly be a great advance if we could diagnose and adequately treat prophylactically these cases at their inception.

We have further divided the postural scolioses into three categories, which for the sake of simplicity we have called groups 1, 2 and 3. These are demonstrated in the pictures.

Now using this classification we can expect to be able to trace a spine as it deteriorates from the relatively innocuous Group 1 postural scoliosis through all the stages until it reaches the more serious fixed type, or are we going to find that structural scoliosis is fixed from its inception and is thus an entirely different entity from the purely postural scoliosis?

Doctor Jonas Salk, when on a visit to Porhias Hospital, stated that he was convinced that idiopathic scoliosis was due to a muscle imbalance resultant on an unrecognized attack of anterior poliomyelitis and now that all these children have been immunized with Salk vaccine the incidence of idiopathic scoliosis should drop quite dramatically. Of course many other recognized authorities consider the two types of scoliosis as being entirely different clinical entities.

Doctor Michele of New York insists that a tight ileopsoas is the primary factor in the production of idiopathic scoliosis — this being the penalty that man has sometimes to pay for adopting an upright stance.

As is the case in many other diseases where the etiology is obscure or unknown the theories advanced as to the cause of idiopathic scoliosis are legion.

We feel that we have optimum conditions for carrying out a field research of this type and trust that it will not take unduly long until we have, at least, some of the answers.

A word about the treatment we are advising at present.

For Group 1 no treatment is prescribed other than normal routine gymnastics as carried out by all the children.

In fact these children and their parents remain unaware that a scoliosis even exists.

For all the other categories they are advised to sleep on hard mattresses with boards, they are given special back exercises, the frequency and duration of which depends on the degree of scoliosis. Leg length inequality when present is corrected by suitable raising of the shoe. Group 2 have X-ray control, AP standing, at yearly intervals. Other categories are usually controlled every three months by X ray and clinical examination.

Incidentally in the 5,000 examinations carried

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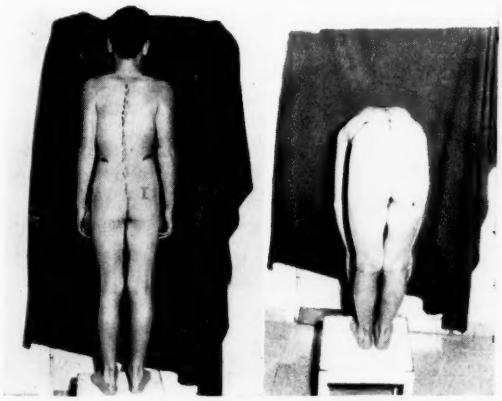
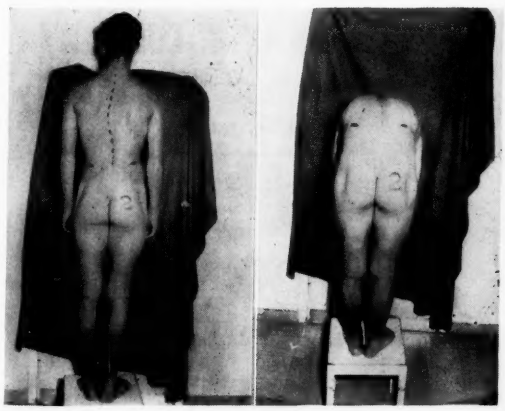


FIGURES 5 and 6

Fig. 5: *Scoliosis: Functional: Group I: Standing.* Scoliosis barely visible with little if any body asymmetry. The scoliotic angle is under 10°.

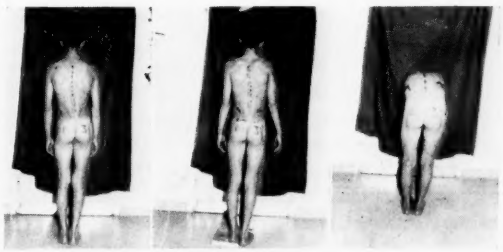
Fig. 6: *Scoliosis: Functional: Group I: Forward Flexion.* The scoliosis disappears on forward flexion.



FIGURES 7 and 8

Fig. 7: *Scoliosis: Functional: Group II: Standing.* Scoliosis more obvious. The left shoulder is higher than the right, as is the scapula. There is inequality of the lumbar arm triangles on each side. The pelvis is level. The curve in this group is usually less than 20°.

Fig. 8: *Scoliosis: Functional: Group II: Forward Flexion.* Here the scoliosis disappears.

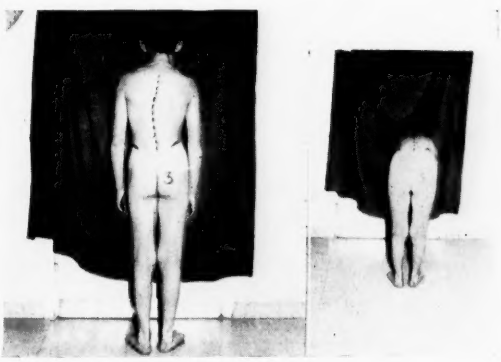


FIGURES 9, 10 and 11

Fig. 9: *Scoliosis Associated with Pelvic Obliquity. Functional. Group III: Standing.* In Group III where the curve is more than 20°, the scoliotic angle is so high and body asymmetry so marked that one would expect this to be a fixed scoliosis, but once again, on forward flexion the scoliosis disappears. This slide shows a youth with Group III scoliosis associated with pelvic obliquity up on the right due to leg length inequality. The C curve to the left is compensatory. The body asymmetry is noted.

Fig. 10: *Scoliosis Associated with Pelvic Obliquity. Functional. Group III: Standing with Raise Under Left Foot.* A 2 cm. raise under the left foot levels the pelvis and the scoliosis is much improved.

Fig. 11: *Scoliosis Associated with Pelvic Obliquity. Functional. Group III: Forward Flexion.* This being a postural scoliosis that straightens out on forward flexion even without a leg raise.



FIGURES 12 and 13

Fig. 12: *Functional Scoliosis: Group III: Pelvis Level. Standing.* The scoliosis and body asymmetry is noted.

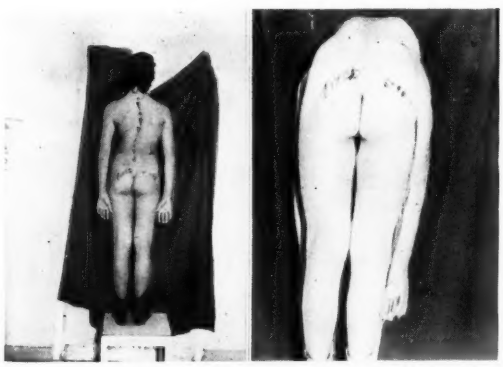
Fig. 13: *Functional Scoliosis: Group III: Pelvis Level. Forward Flexion.* Scoliosis disappears on forward flexion.

out, only one child was found to have a congenital scoliosis. This was due to a hemivertebra and she is classified in Group 2.

34% of all children showed some degree of scoliosis. This includes both postural and fixed types. The fixed type accounting for some 3% and the postural 31%. Generally the incidence in girls is slightly higher than that in boys. Here, there is an increase of the incidence of scoliosis with age. Approximately 10% in the younger children, reaching its peak 50% at the age of twelve years and gradually declining and we may assume that this falls rather rapidly after fifteen years, but in those cases that do persist we may later expect low back pain of the postural type due to the altered body mechanics.

Of the 34% children with scoliosis 54% were girls and 46% boys. In girls, 70% were functional and 30% structural while in boys some 90% were functional and only 10% structural. This conforms with the generally accepted finding that structural scoliosis is far more common in girls than in boys, although the percentage of purely postural scoliosis is approximately equal in the two sexes.

Scoliosis associated with pelvic obliquity. Here, 40% girls with functional scoliosis exhibited pelvic obliquity due to leg length inequality and 55% in the structural scoliosis. In boys, 20% leg inequality in postural scoliosis and 45% in structural scoliosis. It is clearly apparent that pelvic obliquity is an important factor in association with all idiopathic scolioses and these figures appear to indicate that it plays no minor role in the production of a fixed scoliosis.



FIGURES 14 and 15

Fig. 14: *Fixed Scoliosis — Standing.* This girl, age thirteen years has a moderately severe mid-dorsal scoliosis to the right. There is obvious body asymmetry but the pelvis is level.

Fig. 15: *Fixed Scoliosis — Forward Flexion.* The scoliosis persists and there is a razor-back deformity dorsal to the right and lumbar to the left. This girl is being carefully controlled — should the scoliosis deteriorate then surgical fusion would be indicated.

Direction of Scoliotic Curve

In the postural or functional scoliosis, 90% of the scoliosis was to the left and the remainder to the right while in the fixed scoliosis in girls some 50% was to the left—35% "S" type and the remainder to the right. In boys, 91% to the left and 9% to the right. We did consider that the direction of the scoliotic curve might be associated with usage and muscle power of the shoulder girdle. Thus, right-handed individuals most likely would develop a curve to the left and vice versa; but this was not borne out by the survey. In fact, all the children in that smaller group with curves to the right were actually right-handed.

In one particular Kibbutz we did find one common factor. This Kibbutz is intensely idealistic and they firmly adhere to the principle of complete and total equality of man. In their school classrooms the desks are arranged in a "U" around the teacher so that no child is thus favored with a front seat. They all sit equidistant away from the teacher. They have retained their positions throughout their years in school and it is a fact that those children who have habitually sat to the right of the teacher have developed a postural scoliosis to the right whilst the opposite held true for those children who sat throughout the years on the teacher's left. This we expect to control by getting the children regularly to cross over sides in their classroom.

It has been also suggested that maybe the curve followed the direction of political affiliation. But we must confess that we did not discover more curves to the left in the pink-tinged Kibbutzim.

SPONTANEOUS RUPTURE OF AN UMBILICAL HERNIA MANIFESTED BY SEVERE HEMORRHAGE

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The Author. *J. Merrill Gibson, Jr., M.D., of Providence, Rhode Island. Assistant Surgeon, Department of Surgery, Rhode Island Hospital.*

SPONTANEOUS RUPTURE of umbilical hernias is unusual, only four cases having been reported in the American literature.[1,2,3] An exhaustive study by Helmig yielded only sixteen cases from the world literature.[4] The case to be reported here is especially unusual in that the perforation of the hernia was accompanied by severe hemorrhage. I have been able to find no other case reports of spontaneous perforation of an umbilical hernia with hemorrhage.

Case Report

Rhode Island Hospital No. 635313, E. M., a forty-year-old white male was admitted to the Rhode Island Hospital in April, 1960, with active bleeding from the umbilicus. Six days prior to admission the patient had cleaned his umbilicus with his fingernail in the course of bathing. Shortly thereafter he noted a few drops of blood in the umbilicus but attributed it to irritation and ignored it. Three days prior to admission he again noted a small amount of blood. About one-half hour prior to admission he was moving his bowels when he suddenly found himself "covered with blood" emanating from his umbilicus. Attempts were made to stop the bleeding by holding towels against it, but after two towels had been soaked he was taken to the hospital.

Physical examination revealed a blood pressure of 170/110, pulse 92. There was blood flowing from the umbilicus. The abdomen was moderately obese and the umbilicus was funnel-shaped, narrow, and deep. In the course of examination to determine the site of bleeding, the umbilicus was gently probed and a communication to the peritoneal cavity was found. A diagnosis of perforated umbilical hernia was made, and the patient was prepared for immediate surgery. The bleeding was temporarily controlled by packing.

At operation a tiny umbilical hernia with a ring of about 8 mm. and a length of 2 cm. was found. A small perforation about 2 mm. in diameter was found in the skin of the umbilicus, communicating directly with the tip of the hernial sac. A small piece of omentum was incarcerated within the sac and when withdrawn was found to be bleeding actively. The bleeding point in the omentum was ligated, and the hernia repaired, including removal of the umbilicus with its perforation. The patient's postoperative course was uneventful.

Discussion

The most common predisposing cause of spontaneous perforation of hernias is increased intra-abdominal pressure caused by ascites. In this case there was no increased pressure except that produced by straining at stool. I doubt that the trauma of cleaning the umbilicus caused a perforation, but it probably did start a mild inflammation leading eventually to ulceration of skin, hernial sac, and omental blood vessel.

Conclusion

An unusual case of severe hemorrhage from the umbilicus associated with spontaneous perforation of an umbilical hernia is presented. It is believed that this is the first case of its kind to be reported.

BIBLIOGRAPHY

[1]Bontecou, R. B.: Rupture of an umbilical hernia, and escape of a large mass of intestines; peritonitis, opium, recovery, Am. M. Month, N. Y., 1858, pp. 341-344

[2]Lerner, S., and Rust, M. D.: Spontaneous Abdominal Paracentecis, J.A.M.A. 170:1310, 1959

[3]Francis, W. W.: Spontaneous Rupture of Herniae, R. I. Med. J. XLIII:39, (Jan.) 1960

[4]Helmig, Von H.: Uber Sogenannta Spontan Rupturen Von Hernien. Schweizerische Medizinische Wochenschrift, 88:662, 1958 (Abs: Internat. Surg. Digest, 66:360, Dec. 1958)

FANCONI-DE TONI-DEBRÉ SYNDROME

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In 1931, Fanconi described a syndrome characterized by glycosuria, amino-aciduria, phosphaturia and renal loss of base. De Toni in 1933, and Debré in 1934, described patients who showed renal glycosuria and phosphaturia.[2]

The clinical features of this syndrome that are present in various combinations and varying with the stage of the disease include symptoms of: polydipsia, polyuria and photophobia. Physical findings include: dwarfed appearance, blond hair, blue eyes, fair skin and rickets, with bowlegs, enlargement of the wrists and knees and costochondral beading. Laboratory studies demonstrate: acidosis, glycosuria, hyperamino-aciduria, organic aciduria, hypo —or normal calcemia, hypercalciuria, albuminuria, hypophosphatemia, hypokalemia,[4] hyperphosphaturia, and in more advanced stages, uremia.

The etiology of this syndrome is obscure. Many of the workers in this field consider the Fanconi syndrome a varient of cystinosis.[3] It is now known that Fanconi's original patient had cystinosis.[2] One main theory believes that this is a disorder of the metabolism of cystine which is deposited as crystals in the cornea, renal tubules and reticuloendothelial system. Accordingly, this cystine deposition later leads to defective renal tubular functions and ultimately renal failure. Many of the cases summarized by Worthen and Good[1] showed cystine deposits throughout various organs at autopsy. Other typical clinical cases, however, did not reveal cystine deposits at autopsy. Wilkins reports that the original patients described by de Toni and Debré probably did not have cystinosis. Worthen and Good in their cases found normal plasma amino acid levels and cast doubt on the theory of a defect in protein metabolism as this theory is based on the assumption that the plasma amino acid level is increased. They feel that a renal abnormality exists which consists in a tubular defect in resorption of glucose, phosphorus, amino acids and fixed base. The etiology of this renal abnormality is obscure. In some cases, a hyperparathyroidism occurs, secondary to hypocalcemia. This further contributes to the hypophosphatemia and hyperphosphaturia.

The treatment at present is supportive and symptomatic. Excess base is usually given in the form of sodium and potassium citrate to compensate for the excessive renal loss. The rickets usually heal on large doses of Vitamin D. The tendency to develop infection, especially urinary tract infection, is treated with appropriate antibiotics. Electrolyte disturbances are common and often blood chemistries are needed for a rational approach to their correction.

The present case demonstrates the typical findings described in the literature for this syndrome. An additional finding at autopsy included a perforating duodenal ulcer. The association of this with the syndrome has not been previously reported.

Report of a Case

The child was born in England on 4 November, 1953. The product of a full-term normal delivery, he weighed six pounds and eleven ounces (approximately 30-40 percentile) at birth. Breast-fed for the first two months of life, he had a great deal of difficulty with feedings, characterized by frequent vomiting. In spite of this, he doubled his birth weight at six months. His weight then remained stationary between six to ten months of age. This prompted referral to a hospital in England for study. There was frequently mucus and occasionally streaks of blood in the vomitus. Stools were constipated. The child had polydipsia (constantly thirsty), polyuria (diapers were always wet), and was probably photophobic (cried in sunlight).

The family history was essentially negative except that a maternal aunt had kidney trouble.

Physical examination at the age of ten months revealed a very fair-skinned child with blue eyes. There was dwarfism present with the child being 25⅜" in length and weighing thirteen pounds (both below three percentile). The child showed evidence of chronic dehydration. He showed the presence of

rickets with visible epiphysial enlargement of wrists and a ricketic rosary. A barium swallow revealed a congenital narrowing of the lower end of the esophagus. Laboratory studies at that time revealed: serum alkaline phosphatase 69 (KA) units, serum inorganic phosphate 2.5 mg/100 ml., blood urea nitrogen 38 mg/100 ml., serum calcium 9.4 mg/100 ml., alkali reserve 23 mEq/L, total protein 8.0 gm/100 ml., serum albumin 4.75 gm/-100 ml., serum globulin 3.25 gm/100 ml., potassium 9.8 mg.%, chloride (as NaCl) 625 mg.%, sodium 312 mg.%.

Urine showed traces of albumin; specific gravity, 1.016. Urine tested daily showed glucose on one specimen only. Paper chromatography revealed excess amino acid excretion.

Slit lamp examination revealed no crystals in the cornea. He was placed on 20,000 units of Vitamin D daily, and transferred to the Hospital for Sick Children, Great Ormond Street, London, England. During that hospitalization, while attempting to pass a child's bronchoscope into the esophagus, the right side of the esophagus split and air entered the right pleural cavity. The air was removed by using a needle and underwater seal. A gastrostomy was performed at this time and feedings were given through a gastrostomy tube.

At the age of fourteen months, Albright's solution was started in a dose of 15-cc. daily, in addition to the 20,000 units of Vitamin D, daily. Albright's solution consists of a mixture of citric acid, 140 grams; sodium citrate, 98 grams; q.s. water to 1,000-cc. At this time the patient developed a urinary tract infection. This was treated with Gantrisin and his temperature returned to normal after three weeks of therapy.

At the age of two years, repeat X rays of the bones revealed no rickets. Paper chromatography on a twenty-four-hour urine specimen done at this time was reported as normal. Laboratory studies at this time revealed blood urea nitrogen, 100 mg/100 ml.; plasma bicarbonate, 16 mEq/L; plasma chlorides, 110 mEq/L; and, alkaline phosphatase, 18 (KA) units/100 ml.

At the age of twenty-six months, the child returned with the parents to the United States and was seen at the Hunter Air Force Base Hospital, Savannah, Georgia. Physical examination at this time revealed his weight to be eleven pounds and twelve ounces; he was a fair-skinned, very light-haired little boy in no acute distress. His abdomen was somewhat distended. There was a questionable uremic odor to his breath. X-ray examination of the skeleton at this time, including the spine, ribs, pelvis, thighs and legs, revealed some demineralization of the femorae, tibiae and fibulae, but no intrinsic bony abnormalities or evidence of rickets. Laboratory studies at this time revealed nonprotein nitrogen, 54 mg. per cent; serum chlorides (as NaCl), 691 mg. per cent; calcium, 11.6 gm. per cent; and, inorganic phosphorus, 4.5 units, hemoglobin, 11.5 grams. The child's treatment consisted of Albright's solution, 15-cc., daily, and Vitamin D, 20,000 units, daily. His progress was followed periodically at Hunter Air Force Base Hospital Pediatric Clinic.

At the age of three years, he weighed fifteen pounds and three ounces and was 28¾" tall. At the age of 4 3/12, he developed a mild upper respiratory infection. Checkup urine at this time revealed four-plus albuminuria although he was having no dysuria but was having some frequency. He was eating well and sleeping well. He was admitted to Hunter Air Force Base Hospital at this time for study. Physical examination on admission to the hospital revealed temperature, 99.2°F.; pulse, 160/min.; weight, 21¾ pounds; and, respiratory rate was 30/min. Eyes were very blue and he had blond hair. Lungs were clear. Anterior fontanelle was still open. Heart revealed no murmurs. The abdomen revealed a scar in the midline above the umbilicus and slight muscular rigidity of both lower quadrants. Laboratory studies at the time of admission revealed hemoglobin of 10 grams,

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Patient at age four years. The dwarfed appearance, fair skin, blond hair are evident. (Height 30 inches; weight 20 lbs.)

white blood cell count was 12,000 with a differential count of 64% neutrophils, 32% lymphocytes, 2% monocytes and 2% stabs. Admission urine revealed slight alkaline reaction, specific gravity, 1.010; two-plus albumin, trace of sugar, negative acetone, 6-8 WBC, some granular and hyaline casts. Blood chemistries revealed NPN 94 mg.%; FBS 124 mg.%; serum chlorides, 615 mg.%; calcium, 7.5 mg.%; inorganic phosphorus, 9.2 mg. per cent; total protein was 7.4 grams% with 5.2 grams% albumin and 2.2 grams% globulin. X rays of the long bones revealed a marked degree of osteoporosis throughout all the long bones. There were also numerous soft tissue calcific densities noted in the lungs and soft tissue of the viscera. Urine culture grew out gram-negative rod which was inhibited by chloromycetin.

He was placed on chloromycetin and continued on M-solution (citric acid 32.3 gms., potassium carbonate 8.8 gms., magnesium oxide 3.8 gms., q. s. water 1000 cc.) 4 teaspoonfuls daily and Vitamin D 20,000 units daily. He had abdominal pain off and on and began to pass some tarry stools on the seventh hospital day. These were at first small in amount and number and no fall in his hemoglobin was noted during this time. The repeated small episodes of gastrointestinal bleeding were thought to be secondary to uremia. However, on the 17th of March 1958, he vomited a huge amount of blood, passed bright red blood in his stools and proceeded to go into shock. A cutdown was performed, giving whole blood, which brought his hemoglobin back to 11.4 grams. He continued to be somewhat lethargic and his appetite was very poor. He was placed on a modified sippy diet. On the 19th of March 1958, he had another sudden episode of massive hematemesis and died.

Autopsy

Lungs showed peripheral emphysema and patchy areas of resorption atelectasis. Vascular congestion of the spleen with a sinus endothelial hyperplasia was noted. Hexagonal cystine crystals were seen in clumps and diffusely throughout the splenic pulp, liver and lymph nodes. There were mucosal ulcerations of the esophagus. There was an ulceration in the duodenum that showed the ulcer bed to be covered with necrotic material. There was a patrially necrotic vessel projecting from the center of this ulcer bed. The ulcer had extended through the wall of the duodenum and involved the serosal structure adjacent to the pancreas. The cortex of the kidneys was thinner than normal. Glomeruli were hyalinized and there was marked tubular atrophy. Interstitial tissue showed increased fibrous elements with mononuclear cell infiltrate and cystine crystals. Adrenals were normal.

SUMMARY

A case of Fanconi-de Toni-Debré Syndrome is reported. This case demonstrates the typical findings described in the literature for this syndrome. The patient died at the age of four years and five months. An autopsy was performed which revealed crystalline deposits in the liver, spleen, kidney and lymph nodes. An additional finding was a perforating duodenal ulcer which, according to the authors' knowledge, has not been previously reported in association with this syndrome.

REFERENCES

[1]Worthen, H. C., and Good, R. A.: The de Toni-Fanconi Syndrome with Cystinosis, A.M.A.J. Dis. Child. 95:653-688, Jun 1958

[2]Wilkins: Endocrine Disorders, Springfield, Charles C Thomas, 1957

[3]Israels, S. and Suderman, H. J.: Cystinosis, J. of Ped. 47:73, 1955

[4]Fellers, F.; Martner, J.; Ring, H.; Satjadiabrata, J.; Hsia, D.; Craig, J. and Metcoff, J.; Defects in Potassium and Water Metabolism in Cystine Storage Disease, A.M.A.J. Dis. Child. 93:67, Jan-Jun 1957

Editorials

FROM THE EDITOR'S DESK

WITH THIS NUMBER the writer assumes the task of editing the JOURNAL. We are fully conscious of the important responsibility which this represents and of our own limited powers to fulfill the needs adequately. During our active career in the practice of medicine in this community the JOURNAL has been under the guidance of three distinguished editors: Doctor Albert H. Miller, anaesthetist of national reputation and a medical leader of unbending rectitude; Doctor Peter Pineo Chase, surgeon, possessor of a salty Cape Cod wit, writer of a popular newspaper medical column, and authority on Doctor Samuel Johnson; and Doctor John E. Donley, psychiatrist, authority on forensic medicine, a classical scholar of wide scope, and a writer of great charm. The important contribution to the success of this JOURNAL by the estimable and highly intelligent John E. Farrell, its efficient managing editor, must not go unmentioned. Under the leadership of these men the JOURNAL has attained a position of unusual maturity and excellence among state journals. It is our personal opinion that the JOURNAL reached its point of highest quality under the editorship of Doctor Donley. It will be difficult indeed to maintain, much less exceed, these standards.

We do not foresee any radical or important changes in format or content. Our main emphasis will be on improving and broadening the scientific scope of the JOURNAL. We bespeak the co-operation of the membership of the Society toward this end. Think of us when you have papers to publish.

S.J.G.

AUTO EXHAUST, SMOG AND HEALTH

ATTENTION WAS CALLED in the NEW YORK TIMES of August 14 to the California law passed last April requiring that every new car registered in that state be equipped with an anti-smog device within a year after the state's Motor Vehicle Pollution Control Board tests and approves two such devices. The purpose of the law is to reduce air pollution by automobile exhaust fumes. Within three years of such approval all motor vehicles, with a few exceptions, will be required to carry such devices.

The peculiarities of California's coastal climate is to a considerable degree responsible for the production of smog. Unburned hydrocarbons, together with atmospheric layers of differing temperatures, weak winds, and intense sunlight act through a photochemical reaction in such a way as to produce smog, which irritates the eyes and lungs, and damages vegetation. The contribution of smog and air pollution with hydrocarbons to lung cancer and other pulmonary diseases remains a serious question. Although factory smoke and outdoor incinerators contribute to the nuisance, motor vehicle exhaust seems now to be the principal offender.

With the stimulus of the California law several manufacturers have become interested in solving the problem. Those reaching the market first will certainly reap a bonanza. California alone has 7,500,000 vehicles. Two chief types of device have thus far proved promising: an afterburner with a pilot flame, and a catalytic converter. At the present time cost seems to be one of the chief obstacles, with an intelligent guess that such devices might retail for as much as $130 to $150. It is hoped that eventually costs may be reduced to a reasonable level.

These developments inevitably raise the question of their bearing upon the local situation. The City of Providence, prodded by the Air Pollution Committee of the Providence Medical Association some years ago passed a model air pollution law. The air over our fair city has now become, from one of the more polluted metropolitan areas, to one of creditable purity. Private incinerators and outdoor fireplaces have been outlawed, and the smokestacks of our industrial plants, equipped by statute with ash-control devices, are watched diligently by smoke control inspectors.

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The contribution to the recurring menace of air pollution by steadily increasing numbers of internal combustion engines, here and elsewhere, however, goes on unabated. Passenger cars, except for old jalopies which burn oil, are, however, not the greatest nuisance. Rather trucks and buses, particularly those foul and noisome monsters of the road, diesels, are by far the greater offenders. When, through the stimulus of the California law, practicable and economic exhaust control devices become available our state and city legislatures should be the very first to fall in line and adopt suitable automotive exhaust statutes.

DEATH, PHILOSOPHY, AND OBTAINING AUTOPSIES

ELSEWHERE in this issue appears the Thirteenth Annual Doctor Isaac Gerber Oration, titled *A Pathologist's Experience with Attitudes Toward Death*, by Doctor Alfred A. Angrist of New York City. In this delightful discourse Doctor Angrist discusses death from the point of view of doctor, pathologist, philosopher, amateur psychiatrist, anthropologist, and historian. The breadth of his learning is evident from his grasp of the idiom of these varied disciplines. His interest in death is not morbid, but comes natural to a practitioner of his special vocation. Doctor Angrist is a pathologist.

His comments regarding death recall the words of another great worker in the vineyard of medicine, Sir William Osler:

> *We speak of death as the King of Terrors, yet how rarely does the act of dying appear to be painful, how rarely do we witness agony in the last hours. Strict, indeed, is the fell sergeant in his arrest, but few feel the iron grip; the hard process of nature's law is for most of us mercifully effected, and death, like birth, is 'but a sleep and a forgetting.'*

Osler, too, called attention to the graceful words of Shelley:

> *Mild is the slow necessity of death;*
> *The tranquil spirit fails beneath its grasp,*
> *Without a groan, almost without a fear,*
> *Resigned in peace to the necessity,*
> *Calm as a voyager to some distant land,*
> *And full of wonder, full of hope as he.*

Yet these eloquent lines scarcely serve to bring us closer to the goal for which we as scientific practitioners of the art of medicine must strive—a postmortem examination on every patient dying within the hospital. A careful reading of Doctor Angrist's thoughtful essay suggests an approach to this problem, but hardly gives an answer in practical terms. Our hospital autopsy percentages must be kept at a respectable level, not to satisfy some impersonal accrediting agency, but because it is necessary for the good practice of medicine. To accomplish this, philosophy undoubtedly has a place, but even more it requires persistence, co-operation and downright hard work by *everyone* in the hospital hierarchy from chief to intern.

MEDICAL RESEARCH

"Money does not do research. Men do."[1]
...JOHN M. RUSSELL, *President, Markle Foundation*

* * *

"But mere equipment can never guarantee progress or insure that research efforts will be successful. Wondrous and indispensable though they are, tools are but extensions of men's hands and minds and capabilities."[2]
... JOHN E. MCKEEN, *President* and *Chairman of the Board*, Charles Pfizer & Co., Inc.

* * *

TREMENDOUS OUTLAYS of public and private funds in recent years have without question developed a lively public interest in medical research. Unfortunately that interest has been fettered by misconceptions on what makes such research successful.

As John Russell clearly proves the point in his recent Harper's article, money can't buy research, although most of our people have been stampeded into thinking that liberal donations to our many fund raising health organizations, and federal subsidies—this year over a half billion dollars—provide the magic mold out of which methodically come scientific medical discoveries.

As a nation we impulsively act on the assumption that "everything has a price." We can be generous to an extreme, and we are extremely patient today as political leaders of both parties augment our private generosity with sizable dispositions of tax moneys to further efforts in medical research. Equally, we became very impatient when, our estimated price paid, a wonder remedy is not immediately forthcoming.

It is true, as John McKeen stated at the dedica-

tion of the fabulous Pfizer research laboratories at Groton in October, "research would wither on the vine if it lacked financial support. It must be paid for, either by taxes or private enterprise." But the mere doling out of millions of dollars, as if by the purchase of all the scientific resources available one can unlock one of nature's secrets and thereby produce, through a "crash program," an immediate cure for a disabling disease, is fallacious.

We have to remember that a praiseworthy objective does not by itself assure success. Our good intentions must be matched by wise actions if we hope to utilize to the full the funds currently being made available for basic biological research. The mobilization of thousands of experts in the various sciences related to medicine does not rely on money alone. It is not difficult, perhaps, to list the qualities that make a good technical assistance expert, but the process of selecting human beings who possess them is far from easy. As Russell points out, we must break the real bottleneck in medical research which he terms the shortage of good personnel.

McKeen finger-points the situation when he states that "... the time when great discoveries were made by a lonely scientist working in a makeshift laboratory is largely in the past. Medical research has grown fabulously in complexity, in costs of instrumentation, in the association and cross-fertilization of thousands of trained perceptive minds which contribute to a common body of knowledge. Work which may continue for months and years without practical results must be sustained. . . ."

In a democratic world we can take pride in the way in which our private industries undertake the tasks of seeking the cure of many diseases, the prevention or lessening of others, and over-all the adding of health productive years to the life of every citizen. We in New England have particular pride at the moment in the remarkable research laboratories opened last month at Groton, Connecticut, where the Charles Pfizer & Company dedicated its new building based on the modular design concept in which a laboratory is an assembly of standard work units. Here a research staff of more than four hundred scientists, technicians, and supporting personnel will seek to fulfill what President McKeen calls "the duty and privilege of competitive industry, which pays its own way, to provide the tools, facilities and atmosphere for the freest expression of man's creative gifts, through which the attainable gifts of future medical research will actually be achieved."

[1]Medical Research: Choked by Dollars. Supplement of *Harper's*, October, 1960

[2]Medical Research: Duty and Privilege. President's address at ceremonies dedicating Pfizer Medical Research Laboratories, Groton, Connecticut, October 6, 1960

COMMITTEE RECOGNITION

THE MANY COMMITTEES of the Society work for the most part far from public view, although their work is basically in the interest of the better medical care and public health service for all citizens. The Society is forever grateful to the men and women who give generously of their leisure hours, and even of their working time, to assemble in committee conferences day and night.

As a profession we seek no publicity for our committee activities. Therefore it is particularly gratifying when the work of a committee is singularly noted, as was the instance recently when the advisory committee to the Registrar of Motor Vehicles was cited for his contributions to the public.

The citation mounted on a special plaque which now hangs in the Medical Library notes this special recognition as follows:

Presented To
THE REGISTRAR'S MEDICAL ADVISORY COMMITTEE
AND THE RHODE ISLAND MEDICAL SOCIETY
* * *
In Appreciation for Outstanding Contributions
To Driver Improvement and Rehabilitation in
Rhode Island
* * *

Presented by
REGISTRAR'S COMMITTEE ON SAFETY AND
PUBLIC SERVICE AWARDS
Romeo D. Asselin
Registrar of Motor Vehicles
August 1960

AND WITH EARLY AMBULATION

This Month's Short, Short Editorial

Hospital costs are now prohibitive to most patients. Hospital costs are rising. Administrators do not know of any way in the foreseeable future to stop this steady rise.

Economies are attempted. Personnel costs increase. More fund-raising drives are put on. Studies are made to show that rates must go up.

A new building at the Mount Auburn Hospital is scheduled for completion in January 1961. "There will be many innovations in appointments. For example, 'built-in ceiling mounted' television receivers for patients." *Mt. Auburn Hosp. Staff News Letter, June 1960.*

. . . Reprinted from
MASSACHUSETTS PHYSICIAN,
October, 1960 issue.

A PATHOLOGIST'S EXPERIENCE WITH ATTITUDES TOWARD DEATH

concluded from page 697

spared its reality. Children obtain their attitudes toward death from the reaction they observe in their elders. The fear of death in the child is precisely the fear of mutilation, hostility and aggression on himself. We should encourage full expression to our deeply felt emotions, and if so impelled, weep freely and unashamed.

A review of our attitude toward death is more imperative now than ever. There exists the possibility of violent death for huge masses of mankind by atomic energy. The impending threat of its use, when this becomes real and immediate, can create panic that will destroy the individual personality and the social order. The incidental psychic havoc and anarchy threatens to outdo the physical destructiveness. In this light, study and evaluation of our reaction to death, the better to control it, is a practical and worthwhile objective. We need the full benefits of applied common sense and reason in this realm, to allow proper play to the emotional element and yet avoid harmful wounding of the personality and the provocation of pathological forms of behavior. To accomplish this, we must rely upon that great hope of mankind, education. Early use of mental hygiene and psychotherapy may be looked upon as the legitimate and necessary extensions of the field of education for the individual and the group. Our knowledge today is sufficient to control the spread of infection and contagion by the dead. Let us arrest the contagion of fear. This demands a rational attitude toward the body and its inevitable disposal.

A true mindfulness of death can become an incentive to a good life and can make for a controlled emotional acceptance of separation from our known surroundings and our loved ones. Refusal to accept the reality of death represents the most widespread modern instance of running away from reality. While allowing proper emphasis on the emotional component, it is essential to avoid harm to the personality of the living and pathological forms of behavior. Let us foster a rational satisfying equanimity for the event of death, and favor thereby the innate deep-rooted desire in all of us to live a creative life and to do some good which will live after us. We have seen what force can be unleashed by tapping hate and prejudice. Let us make creative life the positive, not fear of negative death, the focal point of existence on this earth. The determination of our objectives during life necessarily implies the proper orientation toward death. The fear of death is more to be dreaded than death itself (Publius).

"Teach me to live that I may dread
"The grave as little as my bed."

DISTRICT MEDICAL SOCIETY MEETINGS

WASHINGTON COUNTY MEDICAL SOCIETY

The quarterly meeting of the Washington County Medical Society was held at the Dunes Club in Narragansett, Rhode Island, on Wednesday, 13 July, 1960.

The president, Doctor Henry Grainger, called the meeting to order at 11:25 A.M.

The minutes of the 13 April, 1960, meeting as circulated to the membership were unanimously accepted.

The applications of Doctors Gobeille and Siegmund were returned and signed by the Board of Censors. A motion by Doctor John P. Jones and seconded by Doctor David Dewees to accept the two doctors as members was posed and carried unanimously.

The brochures as requested from the Rhode Island Council of Community Services, Inc. arrived and were distributed to the membership.

A letter from Medical Management of Providence, Rhode Island, was read but evoked little interest.

The secretary was instructed by the president to invite Doctor Earl Mara, president of the Rhode Island Medical Society, to our October meeting. Same was done but due to previous commitments Doctor Mara had to decline until the next meeting.

A brochure from the American Medical Society concerning dissemination of information to interested young students who might want to study medicine was presented. A brief discussion followed and the availability of this information was explained.

It was mentioned to the membership that Doctor Visgilio had moved away from the area although no notice of this fact has been received to date from Doctor Visgilio.

A brief report was given by Doctor Juliana Tatum concerning the last meeting of the committee appointed to investigate the possibility of a Mental Health Clinic.

Mr. Louis Eddy, Physicians Service Claims representative and a guest at this meeting, offered a few comments about the new Federal Employees Program.

The business meeting adjourned.

Doctor Joseph Corsello, guest speaker, then presented an interesting and enlightening paper of *Tuberculosis Today*.

The meeting adjourned at 12:22 P.M.

Respectfully submitted,
JOHN J. WALSH, JR., M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, October 3, 1960. The meeting was called to order by the president, Doctor Irving A. Beck, at 8:30 P.M.

Minutes of the Previous Meeting

Doctor Beck noted that the minutes of the April meeting of the Association had been published in the May issue of the RHODE ISLAND MEDICAL JOURNAL. He stated that the minutes would not be read unless there was a request.

Action: It was moved that the minutes of the April meeting as published be approved. The motion was seconded and adopted.

Report of the Secretary

The secretary reported as follows:

In addition to reviewing applications for membership in the Association, the Executive Committee, at a recent meeting, granted a leave of absence to Doctor Henry M. Litchman who has been assigned a tour of duty with the armed forces of the United States.

The Executive Committee also reviewed the report of the Entertainment Committee which conducted the very successful golf tournament and annual dinner at Newport on September 14.

The Committee also approved of the work of the Program Committee which has already secured Dr. Mark Altschule as the speaker at the meeting on Monday, November 7, and Dr. Simeone of Cleveland as speaker at the annual meeting on Monday, January 2.

The Executive Committee has reviewed the applications for active membership of the following physicians whom it now recommends for election to membership in the Association: Erwin Backrass, M.D.; Alexander M. Calenda, M.D.; Allan A. DiSimone, M.D.; Ivan J. Laszlo, M.D.; John F. Lowney, Jr., M.D.; Julius C. Migliori,

M.D.; Robert L. Nelson, M.D.; Edward Spindell, M.D.; Mario Tami, M.D.; Marshall A. Taylor, M.D.; Leonard J. Triedman, M.D., and William V. VanDuyne, M.D.

Action: It was moved that the applicants for membership be elected. The motion was seconded and unanimously passed.

Announcements by the President

Doctor Beck noted that the following members of the Association had died since the April meeting: Florian G. Ruest, M.D.; Richard Whipple, M.D.; Arthur Hollingworth, M.D.; Margaret B. Ross, M.D.; Charles A. McDonald, M.D.; Herman C. Pitts, M.D.; Emery Pelletier, M.D.; Francis J. McCabe, M.D., and John E. Donley, M.D.

Doctor Beck asked the members in attendance at the meeting to stand in a minute of prayer in memory of the deceased members.

* * *

Doctor Beck announced the program for the Interim Meeting of the Rhode Island Medical Society to be held on November 9 at the Squantum Club, and he urged the members to plan to attend.

Scientific Program

Doctor Beck introduced Doctor Roman Pe'er, chief, Department of Surgery, Poriah Government Hospital, Tiberias, Israel, who discussed *The Problem of Unexplained Upper Gastrointestinal Bleeding.*

Doctor Beck introduced Doctor Littman, cardiologist, Veterans Administration Hospital, West Roxbury, Massachusetts: associate in medicine, Harvard Medical School and lecturer in medicine at Tufts Medical School; former president, New England Cardiovascular Society, who was the clinical discussor for the CPC. Doctor Littman read the case as presented in the printed notice to the membership and then discussed it in detail. His diagnosis was: 1) Acute Bacterial Endocarditis of Aortic Valve; 2) Possible Bicuspid Aortic Valve; 3) Rupture of Aortic Valve Cusp, and 4) Cardiac Failure.

Doctor Forsythe, associate roentgenologist, Rhode Island Hospital, presented the radiological findings in the case.

Doctor Enold Dahlquist, assistant pathologist, Rhode Island Hospital, reported the pathological findings as follows: 1) Congenital Aneurysm of the Sinus of Valsalva; 2) Acut Bacterial Endocarditis, Aortic Valve, with Rupture of Cusp, and 3) Cardiac Failure.

Adjournment

The meeting adjourned at 10:30 P.M.

Attendance was 104.

Collation was served.

Respectfully submitted,

WILLIAM A. REID, M.D., *Secretary*

HOUSE OF DELEGATES
of the
RHODE ISLAND MEDICAL SOCIETY
Report of Meeting Held September 28, 1960

A REGULAR MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Wednesday, September 28, 1960. The meeting was called to order by the president, Doctor Earl J. Mara, at 8:05 P.M. The following delegates were in attendance:

BRISTOL COUNTY: Robert W. Drew, M.D. *KENT COUNTY:* Edmund T. Hackman, M.D., George L. Young, M.D. *NEWPORT COUNTY:* (No delegates present). *PAWTUCKET DISTRICT:* Alexander Jaworski, M.D.; Earl Kelly, M.D.; Robert Hayes, M.D., and Harry Hecker, M.D. *WASHINGTON COUNTY:* Freeman B. Agnelli, M.D. *WOONSOCKET DISTRICT:* Saul A. Wittes, M.D. *OFFICERS OF THE RIMS* (other than delegates): Earl J. Mara, M.D.; Frank W. Dimmitt, M.D., and Arthur E. Hardy, M.D. *IMMEDIATE PAST PRESIDENT OF RIMS:* Alfred L. Potter, M.D. *PROVIDENCE MEDICAL ASSOCIATION:* Irving A. Beck, M.D.; J. Robert Bowen, M.D.; Bertram H. Buxton, Jr., M.D.; Francis H. Chafee, M.D.; Harry E. Darrah, M.D.; Michael DiMaio, M.D.; William J. H. Fischer, Jr., M.D.; Henry B. Fletcher, M.D.; Warren Francis, M.D.; Frank Fratantuono, M.D.; J. Merrill Gibson, M.D.; Stanley Grzebien, M.D.; John C. Ham, M.D.; Walter S. Jones, M.D.; Frank C. MacCardell, M.D.; Frank I. Matteo, M.D.; William S. Nerone, M.D.; Arnold Porter, M.D.; William A. Reid, M.D.; Ralph D. Richardson, M.D.; Carl S. Sawyer, M.D.; James J. Sheridan, M.D., and Stanley D. Simon, M.D. *DELEGATE TO A.M.A.:* Charles J. Ashworth, M.D.

Also present were Doctor Alex M. Burgess, Sr., associate editor of the RHODE ISLAND MEDICAL JOURNAL; Doctor Peter Mathieu, chairman of the Committee on Social Welfare; Doctor Francis B. Sargent, chairman of the Committee on Medical Defense and Grievance; Doctor Stanley Sprague, chairman of the Committee on Industrial Health, and John E. Farrell, Sc.D., executive secretary.

Resolution Regarding Doctor Donley

The Chair recognized Doctor Alfred L. Potter who presented the following resolution:

WHEREAS DOCTOR JOHN E. DONLEY has served the medical profession of Rhode Island with great distinction throughout his lifetime, and

WHEREAS he was President of the Providence Medical Association in 1931, and the Rhode Island Medical Society in 1936-37, and in 1954 he was named by the Society as its Charles Value Chapin Orator, and

WHEREAS his services as Editor-in-Chief of the RHODE ISLAND MEDICAL JOURNAL, after many years as an associate editor and as a member of the Publications Committee, has aided in making that publication one of the best edited medical journals of its kind,

THEREFORE, BE IT RESOLVED that this House of Delegates of the Rhode Island Medical Society, assembled in meeting on September 28, 1960, express its sorrow in the death of Doctor John E. Donley whose contribution to the Rhode Island medical profession, and to this Society, have been so great.

Action: The resolution was unanimously adopted by the House of Delegates.

Report of the President

Doctor Earl J. Mara reported to the House on the activities of the Society since the meeting of the House of Delegates in April. In particular he discussed problems relating to national legislation and especially the new law relating to medical care for the aged; he reported on problems involving relations with the newspapers locally; and he discussed in detail the perplexing problems arising as a result of the polio epidemic in greater Providence during the summer.

He announced that in accordance with the by-laws he was naming as trustee at large to the Board of Trustees of the Medical Library, to serve for the calendar year 1961, Doctor Philip Morrison of Woonsocket.

Report of the Secretary

Doctor Arthur E. Hardy read his report, copy of which had been submitted to the delegates in the handbook.

Action: It was moved that the report be approved and placed on file. The motion was seconded and adopted.

* * *

Doctor Hardy also submitted to the House a plaque awarded by the registrar of Motor Vehicles in Rhode Island to the Medical Society Advisory Committee to that department. The award was given for the meritorious service of the committee.

Report of the Treasurer

Doctor Mara stated that Doctor Beardsley was not in attendance at the meeting, but his report had been submitted to the delegates in the handbook.

Action: It was moved that the report of the treasurer be approved and placed on file. The motion was seconded and adopted.

Recommendations from the Council

Doctor Hardy submitted the following recommendations from the Council upon which the House took action as noted:

1. The Council recommends to the House that the Annual dues assessment for 1961 for active members more than one year in practice be $50 and for members in their first year of practice, $25.
   Action: The House voted to adopt the recommendation.
2. The Council accepted the report of the Utilization Committee and the recommendation therein adopted by the Medical Economics Council of Rhode Island.
   Action: The House voted to accept the report of the Utilization Committee of the Medical Economics Council and to submit it to the district medical societies and urge them to implement the program as proposed in the report.

Report on the Council of the New England State Medical Societies

Doctor Francis B. Sargent, president of the Council of the New England State Medical Societies, gave a brief oral report on the meeting of that Council held in Boston on Sunday, September 25, 1960.

Election of Editor-in-Chief of the Rhode Island Medical Journal

Doctor Mara noted that under the by-laws he was privileged to appoint a new chairman to the Publications Committee and the editor to the JOURNAL; but in view of the meeting of the House of Delegates scheduled at this time he felt that the matter should be determined by the House. He reported that he had discussed the matter with Doctor Alex M. Burgess, Sr., associate editor of the JOURNAL, and he asked Doctor Burgess to address the House.

Doctor Burgess paid tribute to the outstanding editorship of the late Doctor John E. Donley, and he reported that during Doctor Donley's illness the work had been carried on ably by the associate editors and the managing editor. He expressed the opinion that Doctor Goldowsky has done much to improve and develop the JOURNAL, and he believed that he warranted consideration as nominee for editor-in-chief of the RHODE ISLAND MEDICAL JOURNAL.

Action: A motion was made to nominate Doctor Seebert J. Goldowsky as editor-in-chief of the RHODE ISLAND MEDICAL JOURNAL and Doctor Alex M. Burgess, Sr. as chairman of the Publications Committee of the Society.

The motion was seconded and adopted.

There were no counter nominations, and a motion to close the nominations was seconded and passed.

Doctors Goldowsky and Burgess were declared elected to the respective offices of editor-in-chief and chairman of the Publications Committee.

Delegate to the American Medical Association

The president announced that the House should consider election of a delegate and alternate delegate to the A.M.A. for a two-year term starting in January, 1961.

continued on next page

Action: A motion was made to nominate Doctor Charles J. Ashworth as delegate and Doctor Arthur E. Hardy as alternate delegate. The motion was seconded.

The attention of the House was called to its action taken at the April meeting in adopting the report of the Committee on Tenure of Officers to the effect that a delegate should serve not more than three successive terms.

Action: A motion was made to nominate Doctor Arthur E. Hardy as delegate. The motion was seconded.

* * *

A motion was voted to close the nominations.

* * *

A motion was made that the House permit Doctor Charles J. Ashworth the privilege of addressing the members. Doctor Ashworth related that he has been elected president of the Aces and Deuces, an organization of A.M.A. delegates from states with one or two delegates, to serve until June, 1961; and, therefore, he asked to be continued as delegate for another term.

* * *

On a written ballot, by a vote of 21 to 14, Doctor Ashworth was elected delegate. Doctor Ashworth expressed his thanks to the House for supporting his continuation as delegate for another two-year term.

* * *

Doctor Arthur E. Hardy was nominated as alternate delegate to the A.M.A. There were no counter nominations, and Doctor Hardy was unimously elected alternate delegate.

Representation on the Blue Cross Board

Doctor Mara indicated that the House should elect two nominees to serve on the Rhode Island Blue Cross Board for the calendar year 1961. Doctor Hardy reported that the present representatives are Doctors Charles J. Ashworth and Charles L. Farrell; and that Doctor Charles Farrell had notified him that he no longer wished to serve in this office.

On separate motions the following were placed in nomination: William J. H. Fischer, Jr., M.D.; Seebert J. Goldowsky, M.D.; Arnold Porter, M.D., and William A. Reid, M.D.

On a written ballot Doctor Porter received the majority of votes and Doctors Fischer and Reid were tied for the second highest vote. Doctor Fischer withdrew his vote in favor of Doctor Reid, and the House declared Doctors Arnold Porter and William A. Reid as its elected nominees to serve on the Blue Cross Board of Directors for 1961.

Report of the Cancer Committee

The president noted that the report was included in the handbook.

Action: It was moved that the report of the Cancer Committee be received and placed on file. The motion was seconded and adopted.

Report of the Committee on Diabetes

The secretary read a brief report from the chairman of the Committee on Diabetes.

Action: It was moved that the report of the Diabetes Committee chairman be received and placed on file. The motion was seconded and adopted.

Medical Defense and Grievance

Doctor Francis B. Sargent, chairman of the Committee on Medical Defense and Grievance, gave an oral report on the recent meetings of his committee.

Action: It was moved that the report as given by Doctor Sargent be accepted. The motion was seconded and passed.

Committee on Medical Economics

Doctor Stanley D. Simon gave an oral report in which he commented on the work of the Medical Economics Council of Rhode Island and on developments of an investment plan for New England physicians by the Council of the New England State Medical Societies.

Action: It was moved that the report as submitted by Doctor Simon be accepted. The motion was seconded and passed.

Special Report on Medical Care for the Over Age Sixty-five Person in Rhode Island

The president called on Doctor Peter Mathieu, chairman of the Committee on Social Welfare, to discuss the special report on Medical Care for the Over Age Sixty-Five Person in Rhode Island, as submitted to the House by the Committees on Social Welfare and Aging.

Doctor Mathieu reported on the development of federal legislation for medical care for the aged, and he reviewed the action at the recent Governor's

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an added measure of protection for little patients

against relapse
against "problem" pathogens

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

pediatric drops
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● full antibiotic activity ● lower milligram intake per dose ● up to 6 days' activity with 4 days' dosage ● uniformly high, sustained peak activity ■ **syrup** (cherry-flavored), 75 mg./5 cc. tsp., bottles of 2 and 16 fl. oz. Dosage: 3 to 6 mg./lb./day—in four divided doses. **pediatric drops,** 60 mg./cc., 3 mg./drop, 10 cc. bottles with calibrated dropper. Dosage: 1 to 2 drops/lb./day—in four divided doses.

PRECAUTIONS: As with many other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs discontinue medication. Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under observation.

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HOUSE OF DELEGATES

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conference at which Mr. Arthur Flemming, Secretary of Health, Education and Welfare, had been the speaker. He stated that the Governor had asked the various agencies at the conference, including the Rhode Island Medical Society, to submit individual opinions which could be used for discussion purposes.

Doctor Mara and the executive secretary also discussed the question before the house.

Action: It was moved that the special report of the Committees on Social Welfare and Aging as submitted to the House be approved for submission to the Governor's Study Committee on Medical Care for the Aged. The motion was seconded and adopted.

Advisory Committee to the National Foundation

The secretary noted that the report of the Advisory Committee to the National Foundation was included in the handbook. It was moved that the report be received and placed on file. The motion was seconded and adopted.

Committee on Public Laws

The president complimented Doctor Agnelli for his excellent report on the Hershey Conference which he had submitted to the delegates and which was included in the handbook.

Action: It was moved that the report as submitted by Doctor Agnelli be received and placed on file. The motion was seconded and adopted.

* * *

The recommendation was made that a copy of this report be sent to the secretary of each county society. The recommendation was accepted.

Committee on Scientific Work

The president noted that the Committee on Scientific Work report was included in the handbook to the delegates. It was moved that the report be received and placed on file. The motion was seconded and adopted.

Committee on Social Welfare

The president noted that the Committee on Social Welfare report was included in the handbook to the delegates. It was moved that the report be received and placed on file. The motion was seconded and adopted.

Physician's Lien Statute

The president briefly reviewed the reason for a proposed lien on claims for personal injuries, and he reported that the proposal had been reviewed by the Council which referred it to the House of Delegates without recommendation.

The subject was discussed by members of the House.

Action: It was moved that the proposed Physician's Lien Law be approved and that in final draft it be submitted to the General Assembly at its January session in 1961. The motion was seconded and adopted.

Report on Physicians Service

Doctor Simon suggested that at the meeting of the House of Delegates a report on the developments in Physicians Service be made by the doctors elected by the House of Delegates to serve on the Board of Directors of that Corporation. He called to the attention of the House that the only information it receives is at the Annual Meeting. There was general agreement that the physician delegates on the Board of Directors of Physicians Service should report to the House of Delegates as do the other committees of the Society.

Action: It was moved that a report on the activities of Physicians Service, including the decisions of the Board of Directors, be on the agenda for each meeting of the House of Delegates and that a report be made by those representatives elected by the House of Delegates to the Board of Directors of Physicians Service.

The motion was seconded and adopted.

Adjournment

The House of Delegates meeting adjourned at 9:58 P.M.

Respectfully submitted,
ARTHUR E. HARDY, M.D., *Secretary*

REPORT OF THE SECRETARY

Since the April meeting of the House of Delegates the Society has been faced with many important issues involving action by various committees as well as the officers of the Society, including the situation arising from the polio epidemic during the summer, the federal legislative activities in the health field, and major public relations problems. The Council has reviewed and commended the activity of the president in these matters, and it has also taken the following actions:

Approved of investments of funds held in the "suspense" account of the Society.

Approved of the tentative budget for 1961 as submitted by the treasurer.

Approved of the listing of the Society as a sponsoring organization for a Rhode Island Administrators Conference on School Health to be held on December 7, 1960, at Rhode Island College, with the Rhode Island Department of Education, Rhode Island Department of Health, Rhode Island College, and the Rhode Island Council of Community Services as other sponsors.

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"Sometimes, when I have a running nose, I'd like to clear it with **TRIAMINIC®**– just to check out that systemic absorption business.

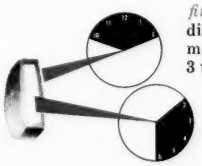
Reaches all nasal and paranasal membranes, huh?"

...and for humans with RUNNING NOSES...

You can't reach the entire nasal and paranasal mucosa by putting medication in a man's nostrils – any more than you could by trying to pour it down an elephant's trunk. **TRIAMINIC**, by contrast, reaches *all* respiratory membranes *systemically* to provide more effective, longer-lasting relief. And **TRIAMINIC** avoids topical medication hazards such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:

½ the formulation of the Triaminic Tablet.

Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:

¼ the formulation of the Triaminic Tablet.

Dosage (to be administered every 3 or 4 hours):
Adults—1 or 2 tsp.; *Children 6 to 12*—1 tsp.;
Children 1 to 6 — ½ tsp.; *Children under 1* — ¼ tsp.

TRIAMINIC®

timed-release tablets, juvelets, and syrup

STOP *running noses* *and open stuffed noses orally*

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HOUSE OF DELEGATES

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Referred to the Committee on Industrial Health communications relating to the 1960 Physician's Award from the President's Committee on Employment of the Physically Handicapped, and relating to a possible conference of state medical society committees dealing with rehabilitation.

Approved of the appointment of a member of the Committee on Disaster to attend the national conference on civil defense and disaster preparedness to be sponsored by the A.M.A. and held in Chicago, November 4-6, 1960.

Received and reviewed A.M.A. resolutions relating to the role of physicians in public affairs, and on prospective medical students.

Commended Doctor F. B. Agnelli, chairman of the Society's Committee on Public Laws, for his attendance at the A.M.A. Conference at Hershey, Pennsylvania in August on political action, and for his excellent report of that Conference. (See report in handbook.)

Reviewed a report from the New England Ophthalmological Society of its committee on ophthalmological-optometrist relations.

Reviewed and referred to the House of Delegates a suggested legislative proposal for a physician's lien on claim for personal injuries.

Appointed Doctor Stanley Sprague, chairman of the Society's Committee on Industrial health, as the Society's official delegate to the 20th Annual Conference on Industrial Health sponsored by the A.M.A.

Respectfully submitted,
ARTHUR E. HARDY, M.D., *Secretary*

REPORT OF THE TREASURER

Appended to this report is a summary of the investment account of the Society, and also a tentative budget for 1961.

The investment account, handled by the Trust Department of the Industrial National Bank, is reviewed periodically, and all investments, or changes in invested holdings, are subject to the decision of the Council of the Society. The Trust Department in its latest statement has notified us that it has examined the "pooled fund" of the Society and it believes the securities are of satisfactory quality and therefore no investment changes are recommended at this time.

The by-laws provide that at the September meeting of the House of Delegates the treasurer shall submit a proposed budget for the subsequent calendar year. Therefore I have submitted a tentative budget for 1961 drafted on the basis of current and past expenditures for the operation of the Society. This budget has been approved by the Council of the Society and it is submitted to the House for its consideration.

Respectfully submitted,
J. MURRAY BEARDSLEY, M.D., *Treasurer*

MEDICAL ECONOMICS COUNCIL

Utilization Committee Report

Aware of the need and urgency for immediate and direct action to evaluate locally the constantly increasing Blue Cross and hospital rates and the mounting volume of public criticism, your Committee presents this report with specific recommendations.

Based upon information from other areas where the problem is present and is being met, as well as opinions expressed by individual members of this Committee, it becomes emphatically clear that the bulk of criticism derives from these two sources:

1. A current belief that hospitals are not operated and administered as economically as possible.
2. The facilities of these hospitals available to physicians for the care of patients are abused or at least not used as efficiently and economically as possible without limiting or lessening good medical care.

While it is obvious that studies in other areas indicate some of the criticism has a basis in fact, though not of the magnitude charged, initiation of corrective action can improve a growing situation here as it has elsewhere. It is not pertinent at this time, however, to attempt to suggest any area of hospital operation wherein economies could be effected. Studies now going on in Massachusetts, Michigan, and New York may be available to us without the expenditure of a sum that would be prohibitive in Rhode Island. Thus, the first source of criticism above mentioned will, for the present, be dismissed.

Regarding the second source of complaint, it is obvious that it is the physician who alone determines the need for a patient's admission to the hospital, who orders the facilities for accurate diagnosis and the therapeutic measures with the accompanying nursing procedures to accomplish relief from, or cure of a patient's disease. The duration of hospital stay, likewise, is the sole responsibility of the doctor. Consequently, it is no less obvious that these medical judgments affect the cost of hospital care as well as the cost of voluntary prepaid plans, and the community's attitude toward the acceptance and justification of such costs.

In view of the foregoing, your Committee is of the opinion that insuring proper and effective utilization of the community's hospital facilities and services is a basic responsibility of the medical pro-

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fession. This responsibility, therefore, can best be discharged through the establishment of an active utilization committee within the medical staff of each hospital. It is suggested that the functions of such a committee at the outset would embrace the following:

1. Review admissions as to necessity and length of stay.
2. Determine that the services used could not have been provided as effectively in some less expensive facility, as the home, office, or out-patient department.
3. Delay in use or over-use of all laboratory, diagnostic and therapeutic services.
4. Delay in consultation and/or referral.
5. Numerical compilation of such cases.
6. Attempt to determine what factors contribute to these defections and what corrective measures might be recommended.
7. Seek collaboration with chiefs of service, department heads, administrative personnel, and staff committee chairmen such as medical records, tissue, operation room, drug, nursing, educational, social service, and others.
8. Meet regularly, at least monthly.
9. Accumulate simple but suitable records for future comparison and analysis.
10. Organize and elect chairmen so that each committee will be able to be active January 1, 1961.
11. The chairman of each utilization committee should comprise a liaison group to report semi-annually to this Council or a designated body of similar objectives.

It should be emphasized that such a committee would primarily be a fact-finding, educational instrument of each medical staff working in close harmony with the administration of each hospital toward a common goal. It would be without authority to effect changes in privileges, procedures or responsibilities of any individual or area of the hospital organization, but by study and recommendation strengthen the entire administrative and clinical structure.

The experience of other groups, meager though it is to date, has demonstrated conclusively that improvement can be achieved by utilization committees. The initiation of such improvement, it has been shown, is the responsibility of the individual physician. It is suggested, therefore, that the Rhode Island Medical Society, representing organized medicine in our community, be apprised of the Council's opinion in this matter by appropriate communication. Recognition of the prime role the medical profession plays in the proper use of hospital facilities and services, as well as the implementation of any measures that will protect the progress prepayment has made, will without question secure the co-operation of the medical society in accepting our suggestion for inaugurating this program. Your Committee suggests the following recommendation be forwarded to the officers of the Rhode Island Medical Society:

> The Medical Economics Council of Rhode Island, after a brief survey by appropriate committees, recommends that the Rhode Island Medical Society act as the official sponsor of a plan to organize and establish utilization committees in each hospital in the state. This could be delegated to the officership of each county medical society within whose jurisdiction a hospital is located. All aid and co-operation of this council will be available to the state society for initiating and implementing this program, in order that as of January 1, 1961, each hospital in the state will have a well-organized utilization committee ready to function along the line suggested in this report.
>
> The Medical Economics Council further recommends that a copy be sent to the Hospital Association of Rhode Island urging its help in securing full co-operation from each hospital through its governing board or trustees, hospital administrators, and the medical staffs.

It is the considered opinion of the Council's committee submitting this report that medicine, that is, the practicing physician, is irrevocably committed to participation in prepaid plans, their continued success, even survival. Over-utilization of hospital facilities seems to be a prime problem at this time, and full co-operation of the profession, individually and collectively, must be patient to all who are close to and concerned with the problem.

CHELCIE C. BOSLAND
EARL F. KELLY, M.D.
STANLEY H. SAUNDERS
I. HERBERT SCHEFFER, M.D.
WILLIAM K. TURNER
CHARLES J. ASHWORTH, M.D., *Chairman*

CANCER COMMITTEE

The Cancer Committee of the Rhode Island Medical Society held its first formal meeting on July 26, 1960, to discuss plans for the Cancer Workshops for general practitioners. The dates selected are three consecutive Sundays: October 2—9—16, and the phases of cancer to be covered on each of these days are lung, cancer in children and lymphoma.

continued on next page

The physicians in charge of these three workshops are Doctors Thomas Perry, Ruth Appleton, and William J. H. Fischer, Jr. Each will be supported in his presentations by very capable contributing panelists. Letters have been written to Dr. Kraemer and to Dr. Erinakes, both of whom represent the American Academy of General Practice, and an effort was made in these letters to try to stimulate interest in improved attendance.

We also discussed the type of Cancer Day which should be conducted in April of 1961 to coincide with the annual Cancer Drive, and it was the general feeling at the meeting that this should be a very high level program stressing the investigative and progressive features in cancer research and cancer therapy. Details of this are being worked out at the present time, and invitations will be sent out soon to the guest speakers.

It was also brought out at this meeting by Dr. Giura that there appeared to be a rather constant break in intraprofessional relationships in the management of patients with malignancy that works constantly to the disadvantage of the general practitioner. By this Dr. Giura implied that a patient first seen by a general practitioner, and subsequently referred to a specialist for evaluation and treatment, was rarely seen again by the general practitioner, and that his knowledge and follow-up of the case was of necessity very scanty.

Respectfully submitted,
HENRY C. MCDUFF, JR., M.D., *Chairman*

MEDICAL ADVISORY COMMITTEE TO THE NATIONAL FOUNDATION

It was agreed that the committee should be enlarged with particular reference to members actively engaged in the treatment of patients at the Charles V. Chapin Hospital and Dr. Silva has written to Dr. Mara requesting the appointment of Dr. J. Dailey and Dr. West to the committee.

It had been learned that in previous years the National Foundation had covered the expenses of patients stricken with polio for a period of thirty days of hospitalization. During the present epidemic, apparently because of the greater case load, the Providence Chapter of the National Foundation has paid for the first fourteen days of treatment at the Charles V. Chapin Hospital for twenty-one patients. Other patients are still hospitalized and their bills have not been submitted to the Foundation.

It was the consensus that the National Foundation should be requested to pay only for *indigent* patients.

The decision as to financial need should be made by the Social Service Department at the hospital while the patient is hospitalized.

It was determined from discussion with Mr. Eddy at Blue Cross–Physicians Service that patients with Blue Cross coverage have been receiving full Blue Cross benefits, and it would appear that in the vast majority of cases, except in those of special need, that patients with Blue Cross coverage would not be required to make application to the National Foundation for financial assistance.

The applicable principle would appear to be to use any private insurance payments first before applying to funds from the National Foundation. It should be determined from the Providence County Chapter whether the funds available in Rhode Island must come only from the local county chapters in Rhode Island. If this is so, then some discussion should be had with the National Foundation to determine if funds could be made available in areas of need without regard to geographical restrictions, considering that in epidemic areas, financial assistance could be available from chapters which are free of disease or the need for appropriation of funds.

It was agreed to discuss with the National Foundation their attitude towards the long-term treatment of paralytic polio cases.

The resolutions of the A.M.A. House of Delegates meeting in Miami Beach, June, 1960, with respect to the National Foundation were reviewed and it was agreed that a meeting with the local committee of the Providence Chapter should be arranged at an early date in order to implement the recommendations of the A.M.A.

MAURICE SILVER, M.D., Chairman

PUBLIC LAWS

Report of A.M.A. Conference at Hershey

On August 26th and 27th I had the privilege of representing the Council of the Rhode Island Medical Society at the regional political action conference held at the Hotel Hershey in Hershey, Pennsylvania.

The meeting was most instructive and its theme

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acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

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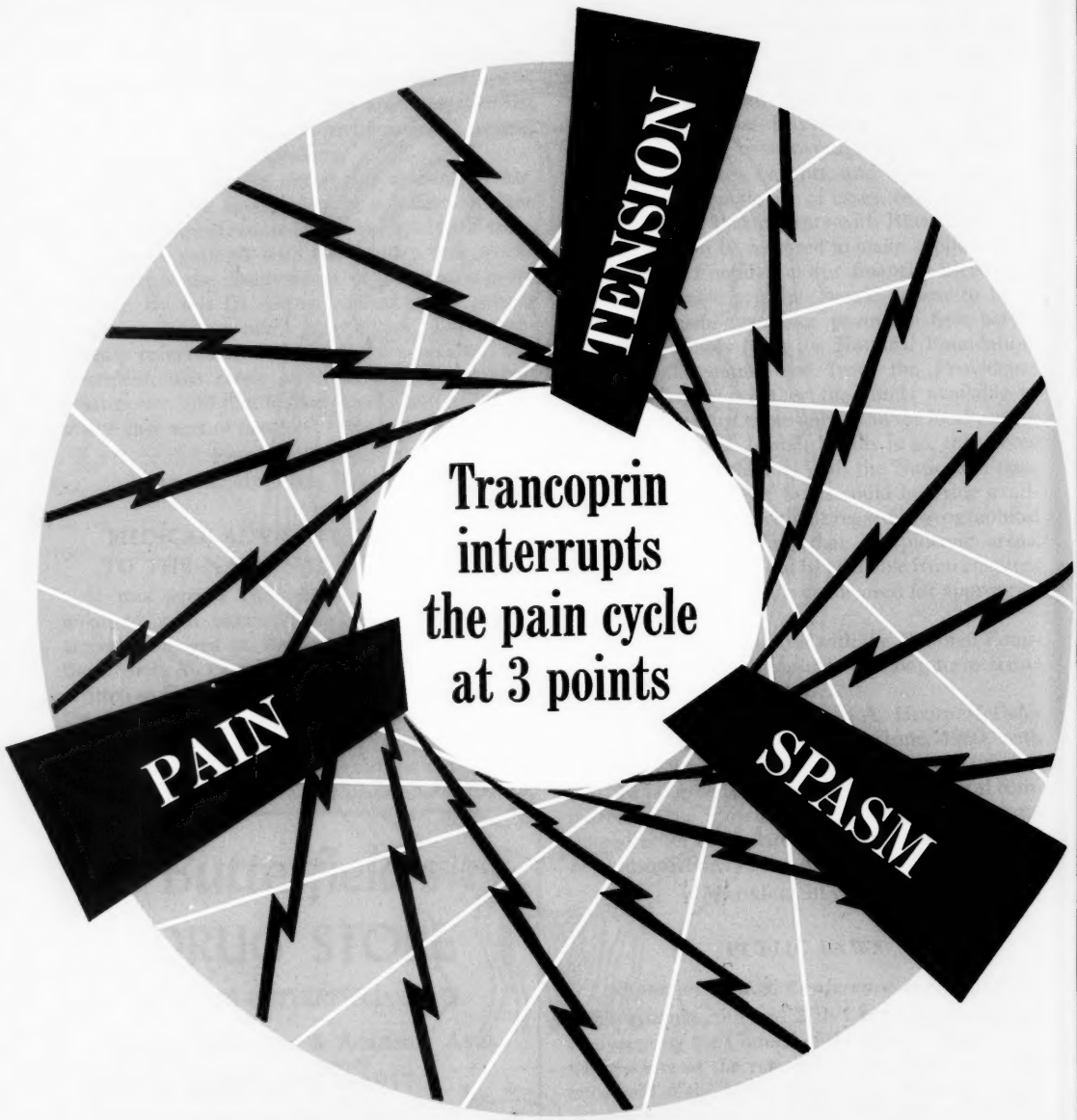

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Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

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Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

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The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

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References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.

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was, *The Role of the Physician in General Politics.* Dr. David B. Allman, a former A.M.A. president, who was chairman of the conference committee, reminded us that physician activities in politics is not new. A physician, Dr. Rush, was the first to sign the Declaration of Independence. The true objective of political action by physicians is, "so that the people in this country get the best possible medicine that can be available to them." Any adverse legislation might conceivably alter and damage medical care in this country. Dr. Allman stressed the importance of the wives of the doctors and their activities on the outside that could influence political action. Several of the speakers stated that it is imperative that physicians take a political stand either for one political party or for the other, it does not matter much which political party. It is important that the average physician be not a "fence sitter" or a so-called independent voter, but an individual who has an interest in politics, either to run for office or to support others who run for office. Only in this manner can the best type of candidate be presented to the American public.

It was stressed that perhaps the most important phase of politics in America, whether it be on the local, state or national level, is the choosing of candidates and not the voting for the candidate who already has been chosen. An individual has no voice in the choosing of a candidate unless he aligns himself with one of the major parties. Several of the speakers also stressed the importance of physicians themselves running for office.

Dr. Ernest B. Howard, assistant executive vice president of the A.M.A., spoke at length concerning medicine and the 86th Congress. He stated that during the time the 86th Congress was in session 19,000 bills were introduced and of these 739 concerned themselves either directly or indirectly with medicine. He stated that the Forand campaign actually started between 1935 and 1938 and at this time it was rejected by President Roosevelt (1938) as being too radical. This campaign was again resumed in 1949 and 1951 by Congressmen Murray and Dingell, and urged by President Truman. At this time the plan of attack was not a head-on attack but a break-through by appealing to the aged.

In 1957 the campaign gained momentum and "all the stops were pulled." They began by a system of "dividing and conquering" and the first that they divided away from organized medicine was the American Nursing Association whom they conquered lock, stock and barrel. They convinced the nurses that the best thing for them was Social Security Medicine. They attempted to capture the American Hospital Association but the A.M.A. blocked them. However, the American Hospital Association could have been lost, as was the American Nursing Association, if it were not for the intervention of the American Medical Association.

The Forand Bill, it was pointed out by Dr. Howard, gained momentum because a non-existing crisis was created. This was started by a series of opinions of half-truths concerning people over 65. Many of these opinions were formulated by so-called "national authorities on Social Security" who made themselves authorities in classrooms and by their writings. We, as physicians, never make ourselves authorities in these matters and it is these people that have actually brain-washed the working press by meaningless statistics and by feature writers who have an audience. Ironically, most of the editorial writers agreed with the American Medical Association, but it seems as though the solons know of the feature writers and not of the editorial writers. This talk by Dr. Howard emphasized strongly the necessity for physicians to engage in politics and to have an active interest on political action.

One afternoon was wholly devoted to organization and methods of operation of politics in general and this program was conducted by Mr. Joseph J. Eley who is a specialist in public affairs counseling. Mr. Eley stressed that both parties are in need of professional members. He stated briefly that there are three main components of politics . . . one, organization; two, candidates; and three, issues; and they rank in importance in that order. In order to win elections two things are necessary, one, voters; and two, dollars. Of the two, voters are much more important than dollars. Regardless of the amount of money that is put into a political campaign, if the voters are not brought to the polls, the campaign is lost, irrespective of the issues. Mr. Eley reminded us of the Kefauver *vs.* Taylor campaign. There is no question in the minds of professional politicians that Mr. Taylor had both the issues and the dollars but he did not have the voters as Kefauver had.

The second day of the meeting was devoted to legal aspects of political activities and a report of several states who are pioneering political action throughout the country. Among the speakers were Dr. Edward Annis of Florida, who heads a rather active Political Actions Committee in that state. Aside from supporting medical legislation and physicians within the state of Florida, this committee in Florida has also contributed financially, regardless of party affiliations, to candidates from other states who were physicians. Sometimes these donations were small but they at least encouraged physicians in other states who were running for offices on a national level.

Dr. Raymond White of Idaho made one terse statement that "apathy, not lack of money, loses elections." Mr. Hugh W. Brenneman, Public Rela-

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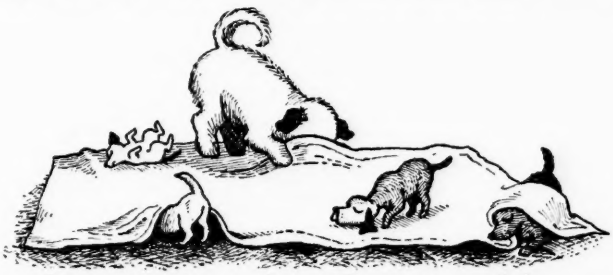
Toes are to wiggle

A lap is so you don't get crumbs on the floor



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HOUSE OF DELEGATES

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tions director of the Michigan State Medical Society, spoke concerning the types of campaigns that are commonly used in politics. There again the theme was not so much issues as the type of candidate that is presented. He has noticed that most elections are won by destroying the opposition rather than by supporting own candidates. In this coming presidential campaign for example, if one were to take a stand against Kennedy, it would not be enough to say that Nixon, or whomever is running against Kennedy, is for this or that issue, but rather that Kennedy has stated opposition to medicine and approval of socialism. He also stated that the Medical Society *per se* is a pressure group and should be utilized as such in politics. It is not necessary for a Medical Society to take sides with one political party or another because it is conceivable that many members of the Society are members of both of the two major parties. It does behoove the Society, however, as a Society, to take a stand on issues, to let candidates know of their stand if it affects American medicine in any way.

Dr. Emerson of Nassau County in New York brought up the fact that labor is trying to dislocate the practice of medicine. He presented a very vigorous program that the physicians of Nassau County in New York State have followed these past several years. They have formed a Guild of Physicians and have actively blocked situations that occurred within their county that would be deleterious to medicine. This Guild, purely a physicians guild, is concerned with politics and also provides many benefits for its members; it even offers a mutual investment fund for its members. A brochure and literature was obtained and will be available at the Medical Library for anyone who wants to look into this Nassau County Physicians Guild.

Dr. John H. Harris of Pennsylvania stressed the importance of the Woman's Auxiliary in activities of legislative committees of the various states.

I take this opportunity to thank you for the privilege accorded me to represent our Medical Society at this conference.

Respectfully submitted,

F. B. AGNELLI, M.D.

COMMITTEE ON SOCIAL WELFARE

The Committee on indigent care of the Council on Medical Service, American Medical Association held a day-long conference in New York City on July 22, 1960. Representatives of medical societies and welfare departments from ten eastern states discussed methods of controlling drug expenditures and welfare medical care programs without ruining the quality of the medical care provided. The Rhode Island Medical Society was represented by John E. Farrell, executive secretary and Peter L. Mathieu, Jr., chairman of the Social Welfare Committee. Also from Rhode Island were Augustine Riccio, director of the Department of Welfare and P. Joseph Pesare, M.D., medical director of the Department of Social Welfare.

Discussion was enlightening and revealing. State programs on indigent care ranged from totally inadequate in some states to moderately effective programs in other states. The state of Pennsylvania felt that its program lacked medical supervision and the president of the Pennsylvania Medical Society felt that the doctors received totally inadequate compensation for care of indigent patients. Several states without vendor payment plans felt doctors were deprived of their fees, in many instances. The state of Florida reported that the indigent patient should have some financial responsibility for his care and that he should be made to pay a partial cost of his prescribed drugs. Maryland reported that cost of drugs represented 50% of their entire budget. It was agreed that the full benefit of an adequate program can be met by the presence of a medical director who can interpret and review problems and policy with the physician.

A summary of four years' experience with the Rhode Island indigent care program (1954-1958) was presented to the assembly. It was pointed out

concluded on page 734

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College of Surgeons Inducts Five Rhode Islanders

The American College of Surgeons inducted five Rhode Island physicians as Fellows of the College at the organization's annual clinical congress held in San Francisco last month. Elected from this state were: Dr. Robert F. Corrente, of East Greenwich, and the following from Providence: Doctors Cyril J. Bellavance, J. E. Caruolo, Warren W. Francis, and Michael E. Scala. Fellowship is awarded doctors who fulfill comprehensive requirements for acceptable medical education and advanced training as specialists in one or another of the branches of surgery, and who give evidence of good moral character and ethical practice.

Ohio Blue Cross Provides "Paid-up-at-65" Plan

A recent issue of MEDICAL NEWS reports that a unique "paid-up-at-age-65" program has been developed by the Blue Cross of Northeast Ohio as a new approach toward financing health care for the aged.

The plan calls for reduction of Blue Cross premiums on a sliding scale for all subscribers with 5 to 40 years of consecutive enrollment prior to reaching age 65.

Completely free hospital care coverage would be offered to persons enrolled for 40 years when they reach age 65. Rates would be halved after 20 years; reduced by 25% after 10 years and 12½% after 5 years.

To finance the program, which was originated by John R. Mannix, executive vice-president of the Blue Cross plan, a 5% rate rise for all subscribers has been requested. This rise, with a 22.4% rate increase to cover mounting costs for existing coverage, is now being studied by the Ohio Department of Insurance.

If passed on schedule, the program may become effective on January 1—and benefit as many as 148,000 subscribers immediately. Of these, one-third may be entitled to a 50% reduction, Mr. Mannix said.

Medicine Launches Campaign to Help Cut Health Care Cost

The American Medical Association is calling upon the nation's physicians to alert the public, their patients, on the latent dangers involved in self-prescribing with the vast number of non-prescription or over-the-counter drug products currently being used at a cost running into millions of dollars annually.

The A.M.A. in a news editorial said physicians also owe it to their patients to discourage them from "throwing their money out the window" on devices, so-called "cures," food fads, "health literature," and many other forms of quackery currently bilking the American public out of additional millions of dollars a year.

The A.M.A. News editorial said in part:

"The quackery, food-faddism phase of the program is a continuation of a concerted, nationwide campaign against door-to-door peddlers, self-styled health and nutrition experts, and manufacturers of useless devices and gadgets being promoted as 'cure-alls' for everything ranging from 'that tired feeling' to arthritis and cancer.

"Physicians are being asked to tell their patients the truth about vitamins, rheumatism, and arthritis remedies and other products being bought by the public and which are essentially worthless in terms of preserving health, relieving pain and suffering, and knocking out disease."

Contributions Through AMEF Increase by 132%

As of June 31, 1960, the receipts of the Foundation were 132% above those through June 31st, 1959—a total of $295,302, as compared to $126,-912 in receipts the previous year. The 1959 figure includes one extra month because the ending of the fiscal year was changed to January 31.

Forty-seven states have shown an increase over last year's figures. It is hoped that this promising trend continues, making 1960 a banner year.

Rhode Island physicians have for the most part

continued on page 732

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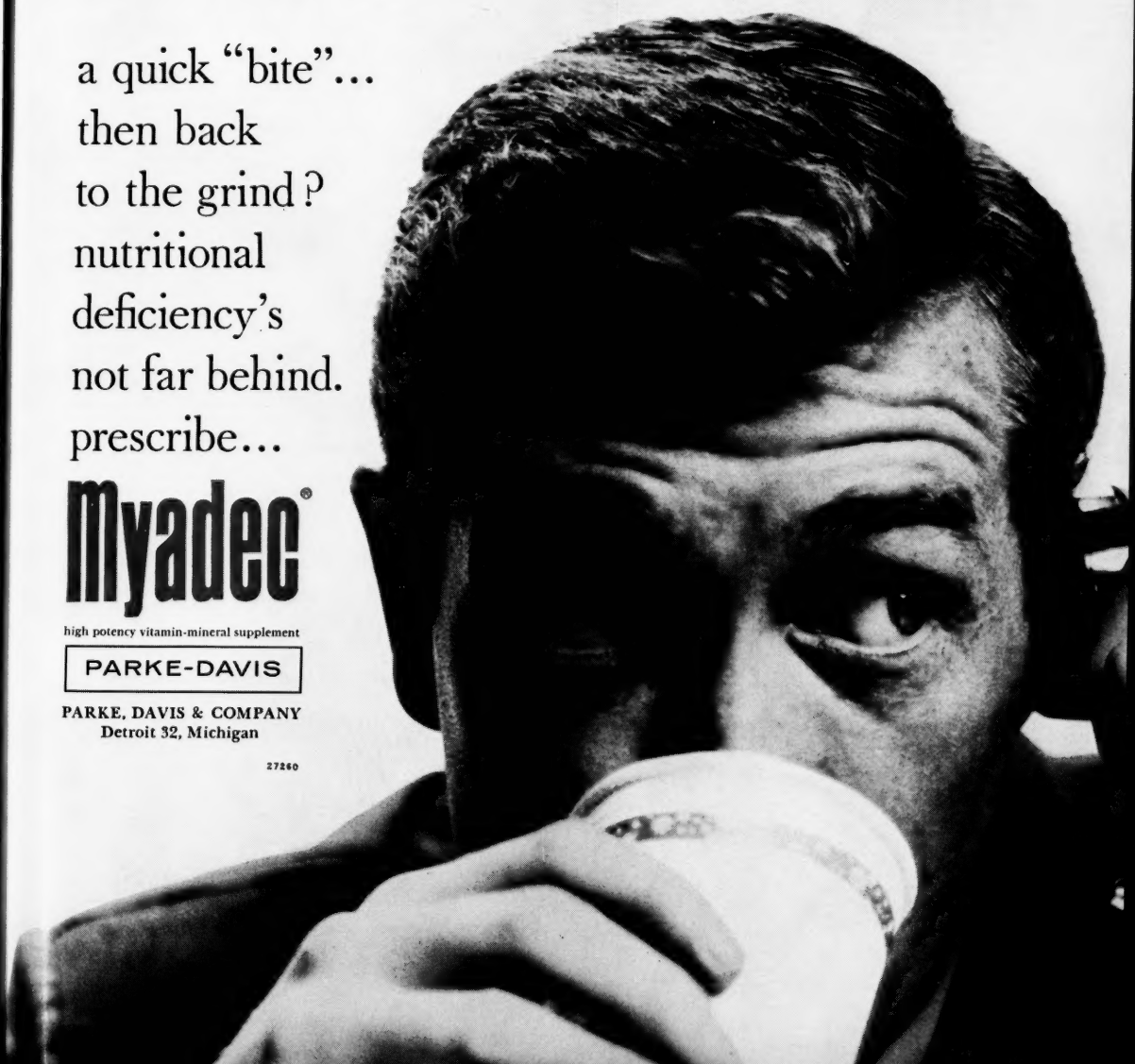

THROUGH THE MICROSCOPE

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preferred to make their medical school gifts directly to the school of their choice, rather than through the AMEF. Thus, in 1959 of the 458 contributors from Rhode Island only 35 routed their donations through AMEF, although the state's total giving of $26,293.60 compared very favorably with states having comparable medical populations.

Group Medical Practice Units Increase Threefold in 14 Years

There are now more than three times as many group medical practice units in the United States as there were in 1946, according to a report presented in New Orleans last month to the American Association of Medical Clinics by Dr. S. David Pomrinse of Washington, D. C.

Dr. Pomrinse, Chief of Health Professions in the U. S. Public Health Service, Department of Health, Education and Welfare, presented a preliminary report on a survey of group practice in the U. S., conducted in 1959, along the same lines as one that was made in 1946. Marcus B. Goldstein, Ph.D., of the Public Health Service, collaborated in the preparation of both reports.

The response of the group practice units studied was almost precisely the same—about 80%—in both studies. Of those responding approximately 37% in both studies were found to be "true" medical practice groups of three or more full-time physicians providing services in more than one medical field or specialty, with their combined income distributed according to a prearranged plan.

In 1946, there were 368 groups of this type and in 1959, 1154 such groups found to be operating in the U. S. Since in both studies 20% of questionnaires were not returned, the total number of such groups in 1946 may be estimated at about 435, and in 1959, about 1,385.

In the 1154 multi-specialty groups of three or more physicians, are 10,085 full-time physicians and 1,365 physicians serving part-time, more than three times as many as in 1946. In addition there are 219 multi-specialty groups having fewer than three full-time physicians in which there are 355 full-time and 3,062 part-time physicians engaged.

While the number of these multi-specialty groups has grown by a national ratio of 3.1 since 1946, the largest regional growth ratio (4.4) has been in the South Atlantic states, followed by the east South Central (4.2) and the Pacific states (3.6). The smallest rate of growth (2.0) has been in the Mountain states and in New England (2.2).

Actually, only 1.5% of all these groups are in New England, while 13% of them are in the middle and South Atlantic states. The Central states account for 63.5%, the Mountain states for 7.3% and the Pacific states for 14.6% of all U. S. groups.

The percentage of all practicing physicians who are in group practice is also lowest in the New England and North Atlantic areas, and greatest in the Midwest. Nationwide, the study reveals that in 1959, 6.21% of all practicing physicians were in full-time group practice and 0.85% more are part-time group practitioners. This compares with 2.64% full-time and 0.35% part-time practitioners in 1946.

As to the size of these medical groups, there have been slight increases in the proportion of groups in the smallest and largest categories since 1946. 57% have from three to five full-time physicians; 24%, from six to ten physicians; 7.5% from eleven to fifteen physicians and 11% have sixteen or more full-time physician members.

The study shows that most newly formed groups are small, and they tend to grow with age. 899 (or 79%) of the 1154 multi-specialty groups with 3 or more full-time physicians, were organized since 1940. The groups reported they planned to add more than 1000 new full-time physician members in 1960.

Medical Emergency Radio Service Denied

The Federal Communications Commission has announced that for the present it will not assign specific radio frequencies for the exclusive use of the nation's physicians.

In not taking any current action on a petition filed by the American Medical Association, FCC said that frequency demand and availability does not justify such an allocation for a new medical emergency radio service. FCC said, however, that alternative means of satisfying such use is under consideration.

The A.M.A. had asked FCC to change its rules so that the medical profession could set up a private two-way radio service. This would be known as Physicians' Radio Service. The petition had explained that medical emergency service is needed not only in routine practice, but also for use in mobilizing physicians during periods of extreme national, regional, or local emergency.

Improvement Reported in Stipends for Interns, Residents

Stipends paid interns and residents showed improvement in many of the nation's hospitals during the year ended June 30, 1960, a report by the American Medical Association stated recently.

The average cash stipend per intern in hospitals affiliated with medical schools was $166 per month, a seven per cent increase over the previous year. In hospitals not affiliated with medical schools, the average stipend was $207, an increase of four and one-half per cent over the previous year.

In addition to the cash stipend, the report said 74 per cent of the hospitals paid full maintenance for unmarried interns, 18 per cent paid partial maintenance while 8 per cent paid none. For the married intern, full maintenance was provided by 52 per cent of the hospitals and partial maintenance by 35 per cent while 13 per cent paid none.

Beginning stipends for residencies also showed improvement.

In affiliated hospitals, the report said 39 per cent of the residencies paid from $101 to $300 per month. In the nonaffiliated group, 41 per cent of the residencies paid from $101 to $350 per month.

A total of 16 residencies paid more than $600 per month, including eight over $700 and two over $950. There were only six residencies over $700 and none over $950, according to the 1958-59 report.

For the 1959-60 academic year, there were 9,457 foreign physicians from 92 countries training in hospitals throughout the United States, the report said. This is a 13 per cent increase over the number reported in the previous year.

The A.M.A. and the Institute of International Education co-operated in taking one census of all interns and residents, including American and foreign graduates.

Six states accepted more than 500 foreign graduates. These were New York with 2,387 or 25 per cent, Ohio with 872 or 9 per cent, Pennsylvania with 619 or 7 per cent, Massachusetts with 573 or 6 per cent, Illinois with 552 or 6 per cent, and New Jersey with 502 or 5 per cent.

Research Findings on Treatment of High Blood Pressure Announced

Research findings concerning choice of treatment for high blood pressure for patients throughout the nation were announced by the Veterans Administration today.

The findings are from the nation's first large-scale controlled test of newer drugs in general use against the disease—a project under way in eight VA hospitals for nearly two years.

Dr. Edward D. Freis of the Washington, D. C., VA hospital, chairman of the study, said the information gained on the safety and relative effectiveness of the compounds should enable doctors to better choose, from among the available antihypertensive drugs, treatment most useful for the individual patient.

For patients with mild high blood pressure, a combination of two compounds, reserpine and hydralazine, was found more effective than reserpine alone. Reserpine alone was found to have little effectiveness against the condition.

For patients with moderately severe high blood pressure, the reserpine-hydralazine combination was considerably more effective than reserpine alone and was better tolerated than and about as

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HOUSE OF DELEGATES

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by the Rhode Island Medical Society had seconded on a number of occasions by all the other medical societies that to be effective the indigent medical care program must be a team effort requiring the understanding and close working co-operation of both the medical society and the Department of Welfare in an effort to resolve problems in a manner which is satisfactory to all concerned within the particular state. It was felt that the Rhode Island Medical Society especially was to be complimented in its ability to attain this relationship and the assembly requested that the entire summary of the Rhode Island state program be included in the minutes of the day which are to be printed and distributed.

Respectfully submitted,

PETER L. MATHIEU, JR., M.D., *Chairman*

COMMITTEE ON SCIENTIFIC WORK

The Committee on Scientific Work has arranged for the Interim Meeting of the Society to be held at the Squantum Club, in East Providence, on Wednesday, November 9, 1960, starting at 3:00 P.M. The program is as follows:

PANEL: Surgical-Medical Management of the Older Aged Persons

Discussors:

WILLIAM H. HARRIDGE, M.D. Clinical Assistant Professor of Surgery, University of Illinois College of Medicine, Chicago, Illinois; Associate Attending Surgeon, St. Francis Hospital, Evanston, Ill.

THOMAS H. MCGAVACK, M.D., *Chief*. Intermediate Service, VA Center at Martinsburg, W. Va.; Professorial Lecturer in George Washington University School of Medicine; 1925 Member, University of California Medical Faculty; 1936 Associate Professor of Medicine, New York Medical College; 1946 Professor of Clinical Medicine, New York Medical College, 1943-1957 Director, New York Medical College and Metropolitan Hospital Research Unit, and Director and past president, American Geriatrics Society.

EDWARD HENDERSON, M.D., Editor-in-Chief, JOURNAL OF THE AMERICAN GERIATRICS SOCIETY; Director and past president of the American Geriatrics Society.

* * *

Evening Program: At the conclusion of the scientific program a social hour will be conducted, to be followed by dinner. A speaker at the dinner is yet to be named.

Auxiliary Meeting: The Woman's Auxiliary will plan to have a meeting at the Squantum Club the same afternoon, and the members will join with the Society at the dinner.

Respectfully submitted,

HENRI E. GAUTHIER, M.D., *Chairman*

Saturday, December 10. **Annual Dinner-Dance. Woman's Auxiliary to the Rhode Island Medical Society (evening).**

Monday, January 9, 1961. **Annual Meeting of the Providence Medical Association, Medical Library (8:30 P.M.).**

PROVIDENCE MEDICAL ASSOCIATION COMING MEETINGS

Monday, December 5, 1960

Role of Chemicals in the Treatment of Advanced Cancer

LOUIS A. LEONE, M.D.

Monday, January 2, 1961

Contributions of Surgical Research to Human Physiology

F. A. SIMEONE, M.D.
(of Cleveland)

AT THE MEDICAL LIBRARY

. . . 8:30 P.M.

What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit among your young patients — and for that matter, your patients of any age — you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

THROUGH THE MICROSCOPE

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effective as reserpine plus ganglion-blocking drugs.

Combinations of reserpine with each of three ganglion-blocking drugs—mecamylamine, chlorisondamine, and pentolinium tartrate—were tested against both moderately severe high blood pressure and severe hypertension.

Each of the three blocking drugs, with reserpine, produced significant reductions in blood pressure. The three were about equal in effectiveness but varied slightly in frequency of undesirable reactions produced.

Chlorisondamine treatment was associated with visual disturbances in patients, and mecamylamine produced slightly more dryness of the mouth and bladder difficulty than did chlorisondamine or pentolinium tartrate.

Of the 101 patients receiving reserpine plus hydralazine, the treatment was discontinued in nine because of development of drug reactions such as headache, stomach upset, or nervousness.

The co-operative study, involving some 320 patients with high blood pressure, was made at the VA hospitals in Brooklyn, N. Y.; Chicago (West Side VA Hospital); Iowa City; Oklahoma City; Richmond, Va.; San Juan, P. R.; Seattle, Wash., and Washington, D. C.

DID YOU KNOW?

- **That at least 53 insurance companies are issuing individual and family health insurance policies which are guaranteed renewable for life or to later than age 65.**
- **That health insurance benefit payments by insurance companies during the first six months of 1960 totaled more than $1.5 billion, up eight per cent over the first half of 1959.**
- **That in 28 of the nation's 50 states, more than 65 per cent of the population have health insurance.**

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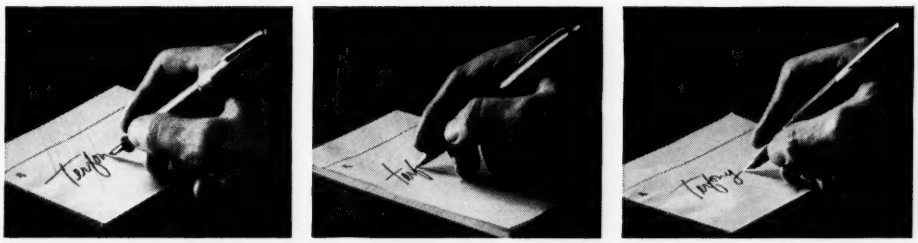
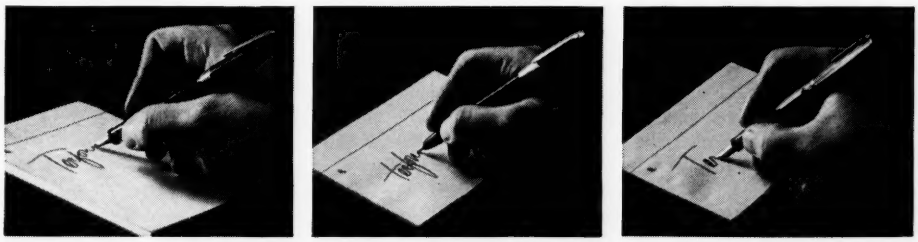


more and more physicians are prescribing this triple sulfa



TERFONYL

Squibb Triple Sulfas (Trisulfapyrimidines)

Clinical experience continues to prove that TERFONYL provides many special advantages fundamental to successful antibacterial therapy.

• specificity for a wide range of organisms • superinfection rarely encountered • soluble in urine through entire physiologic pH range • minimal disturbance of intestinal flora • excellent diffusion throughout tissues • readily crosses blood-brain barrier • sustained therapeutic blood levels • extremely low incidence of sensitization

SUPPLY: Tablets, 0.5 gm. • Suspension, raspberry flavored, 0.5 gm. per teaspoonful (5cc.).

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RHODE ISLAND HAS LOWEST INFANT MORTALITY RATE

Statement issued by the Children's Bureau, Social Security Administration, United States Department of Health, Education, and Welfare, November 2, 1960

THE INFANT MORTALITY RATE in the United States was reduced 7.9 per cent between 1950 and 1958, according to data in the newly published 1959 UNITED NATIONS DEMOGRAPHIC YEARBOOK.

After declining for two decades, the United States infant mortality rate went up from an all-time low of 26.0 deaths under one year per 1,000 live births in 1956 to 26.3 in 1957 and 27.1 in 1958. In 1915, when data were first gathered on infant mortality in the United States, the rate was 99.9 per 1,000. By 1940, this had been cut to 47.0, and by 1950, it had been reduced to 29.2.

(The UN document lists the United States provisional 1958 rate of infant death per 1,000 live births at 26.9. The final official figure for United States infant mortality, 27.1 per cent, was made available since the UN document went to press. On this basis the reduction between 1950 and 1958 was 7.2 per cent.)

The provisional infant mortality rates for the most recent periods—26.4 for 1959 and 25.9 for the first half of 1960—show improvements over the rate for 1958, but Mrs. Katherine B. Oettinger, chief of the Children's Bureau, warned that "these improved rates are still above levels which could have been expected if the general downward trend between 1950 and 1957 had continued."

According to a Children's Bureau analysis of data in the new UNITED NATIONS YEARBOOK, taking into account countries with sizable populations and relatively complete reporting in line with international definitions, nine countries had better records than the United States in 1958 in infant mortality rate. They are:

Sweden, 15.8; Netherlands, 17.2; Australia, 20.5; Norway, 20.5; Switzerland, 22.2; United Kingdom, 23.3; Denmark, 23.4; New Zealand, 23.4; and Finland, 24.5. The UN document reports infant mortality rates for both Norway and Denmark for 1957, latest data available when the report was prepared.

On the same basis of analysis five countries had better records than the United States in 1950. They were: Sweden, 21.0; Australia, 24.5; Netherlands, 25.2; New Zealand, 27.6; and Norway, 28.2.

The Union of the Soviet Socialist Republics reported a rate of 81 deaths under one year per 1,000 live births in 1950 and 40.6 in 1957, latest year for which data were reported.

Mrs. Oettinger said the new UN report makes "all of us feel that we must double our efforts to assure that infant mortality in the United States is brought to and held at the lowest possible point."

No state within the United States matched the low infant mortality rate registered by Sweden for 1958. The United States range among states in 1958 was from 21.3 per 1,000 in Rhode Island to 41.0 in Mississippi, Children's Bureau analysis shows.

Here are some factors in the infant mortality picture in the United States, as analyzed by the Children's Bureau for the period 1950-57:

1. There has been only insignificant reduction in the mortality rate between 1950 and 1957 among infants less than a day old.

2. Progress in decreasing the rate of infant death from prenatal and natal causes has been much slower than for postnatal causes. Studies need to be made about whether prenatal care of high quality is equally available to all mothers, and whether special services are available for mothers threatened with premature delivery or other complications of pregnancy.

3. The death rate for infants of one week to three months of age dropped more slowly during 1950-57 than in the previous period.

4. Progress has been made in decreasing infant deaths from postnatal causes, such as certain infectious and parasitic diseases, diseases of the digestive system, and from accidents. Deaths from infections of unidentified types have shown small but continuing increases. These include pneumonia of the newborn; acute upper respiratory infections and bronchitis; meningitis (except meningococcal and tuberculous); certain "other infections of the newborn"; and septicemia and pyemia. If the death rate for these unidentified types of infections had decreased at about the pace of the death rate for infectious and parasitic diseases as a whole, the lives of some 2,500 infants would have been spared annually in the period 1954-57.

The small but steady increase in infant mortality from ill-defined infections during 1950-58 suggests study, on a community basis, of the roles of hospital-acquired staphylococcal disease, and other infections, the Children's Bureau believes.

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R. I. INFANT MORTALITY RATE

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INFANT MORTALITY RATES

United States, Each State and Territory, and Specified Possessions 1958 and 1950 (By place of residence)

Area ranked on 1958 rate	1958	1950	Per Cent change 1958 from 1950 decrease	increase
United States[1]	27.1	29.2	−7.2	
Rhode Island	21.3	27.8	−23.4	
Utah	22.1	23.7	−6.8	
Vermont	22.4	24.5	−8.6	
Iowa	22.7	24.8	−8.5	
Massachusetts	22.8	23.3	−2.2	
Minnesota	22.8	25.1	−9.2	
Kansas	23.0	25.7	−10.5	
Hawaii[2]	23.1	24.0	−3.8	
Oregon	23.4	22.5		+4.0
Wisconsin	23.6	25.7	−8.2	
Idaho	23.7	27.1	−12.6	
Connecticut	23.8	21.8		+9.2
New Jersey	24.5	25.2	−2.8	
New York	24.5	24.7	−0.8	
California	24.6	25.0	−1.6	
Indiana	24.6	27.0	−8.9	
Michigan	24.6	26.3	−6.5	
Nebraska	24.7	25.0	−1.2	
Illinois	24.9	25.0	−2.7	
New Hampshire	24.9	24.5		+1.6
North Dakota	24.9	26.6	−6.4	
Ohio	25.3	26.8	−5.6	
Pennsylvania	25.5	27.6	−7.6	
Montana	25.7	28.2	−8.9	
Washington	26.1	27.3	−4.4	
Arkansas	26.3	26.5	−0.8	
South Dakota	26.3	26.6	−1.1	
Missouri	26.4	29.2	−9.6	
West Virginia	26.4	36.1	−26.9	
Maine	26.5	30.9	−14.2	
Oklahoma	27.4	30.2	−9.3	
Wyoming	27.8	32.5	−14.5	
Delaware	28.1	30.7	−8.5	
Maryland	28.8	27.0		+6.7
Kentucky	29.1	34.9	−16.6	
Colorado	30.6	34.4	−11.1	
Texas	30.6	37.4	−18.2	
Tennessee	30.9	36.4	−15.1	
Georgia	31.1	33.5	−7.2	
Virginia	31.1	34.6	−10.1	
Florida	31.7	32.1	−1.3	
Nevada	31.9	37.9	−15.8	
North Carolina	32.6	34.5	−5.5	
Arizona	33.0	45.8	−28.0	
South Carolina	33.9	38.6	−12.2	
Louisiana	34.7	34.6		+0.3
Alabama	35.4	36.8	−3.8	
New Mexico	37.3	54.8	−31.9	
Alaska[2]	38.7	51.8	−25.3	
District of Columbia	38.7	30.4		+27.3
Mississippi	41.0	36.7		+11.7
Virgin Islands[2]	44.3	57.0	−22.3	
Puerto Rico[2]	53.2	67.5	−21.2	

[1]Forty-eight States and District of Columbia
[2]By place of occurrence
Source of data: National Office of Vital Statistics